Supreme Court, U.S.
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IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1995

DONNA WINTERS, an individual person,

Petitioners,

v.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM and CONCEPT ADMINISTRATORS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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75 pp

I. QUESTION PRESENTED FOR REVIEW

A. Does the Rule of *Contra Proferentem*, Which Requires Ambiguities in an Insurance Policy to be Construed in the Insured's Favor and Which Courts Apply to State and Other Insurance Policies to Equalize Bargaining Power Between Insurers and Insureds, Apply to ERISA Insurance Plans, Particularly ERISA Insurance Plans that are Drafted by an Employer and Give the Employer Discretion to Interpret Ambiguous Plan Terms?

II. PARTIES

Donna Cole Winters was the plaintiff and respondent below, and is the petitioner here.

Costco Wholesale Group Benefits Program and Concept Administrators, Inc., were the defendants and appellants below, and are the respondents here.

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V. OPINIONS BELOW

Judge William Dwyer of the United States District Court for the Western District of Washington granted summary judgment for plaintiff Winters in an unpublished opinion. *Costco Wholesale Corp. v. Winters,* No. C92-581WD, July 26, 1993. Defendants Costco and Concept appealed to the United States Court of Appeals for the Ninth Circuit. A panel reversed. *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995). The court denied Winters' request for rehearing en banc, against the recommendation of Judge Donald P. Lay.

VI. JURISDICTIONAL STATEMENT

This Court has jurisdiction under 28 U.S.C. § 1254(1).

VII. RELEVANT STATUTE

Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.

VIII. STATEMENT OF THE CASE

After seven years of fruitless artificial reproduction treatments, Ms. Donna Winters conceived in December 1990 thanks to an *in vivo* procedure known as gamete intrafallopian transfer or "GIFT." Conception by GIFT takes place in the woman's fallopian tube.

As a participant in Costco's self-funded ERISA health insurance plan, Winters submitted a claim for the GIFT procedure. Costco, functioning as both insurer and plan administrator, denied her claim. It cited the policy's exclusion for *in vitro* fertilization, or "IVF" procedures (where conception

occurs in a petri dish), and a provision giving Costco discretion to interpret ambiguous or seemingly ambiguous plan terms.

Winters appealed Costco's decision, first because IVF and GIFT by definition are distinct procedures, and moreover because even if the exclusion were deemed ambiguous, the doctrine of *contra proferentem*, which applies to state and other insurance policies, requires coverage ambiguities to be construed in the insured's favor. The district court held for Winters on both points, but a Ninth Circuit Court of Appeals panel reversed.

Departing from a long line of precedent, the panel concluded Costco did not abuse its discretion in applying

the *in vitro* exclusion to Winters' *in vivo* procedure. It held that the rule of *contra proferentem* does not apply to self-funded ERISA plans which purport to give the plan administrator authority to determine benefit eligibility. The court declined to rehear the case en banc.

Winters asks this Court to review the panel's decision. If the scope of the IVF exclusion in Costco's insurance policy was ambiguous, it should have been construed in Winters' favor under the doctrine of *contra proferentem*.

This rule levels the playing field between insurer and insured. Leveling is required because an insured does not participate in the drafting process. *Contra proferentem* also fosters clear,

careful drafting, because it penalizes an insurer (who should be acting as a fiduciary in cases such as *Winters*) for ambiguities.

These effects are particularly desirable where, as here, the employer is both insurer and administrator and has discretion to interpret ambiguous plan terms. Failure to apply *contra proferentem* in such situations leaves the employer's conflict of interest unchecked.

As ERISA's main objectives are employee protection and clarity of coverage, Ms. Winters submits that *contra proferentem* supplements ERISA, and asks this court to hold that *contra proferentem* applies not only to state and other insurance policies but to

ERISA insurance policies as well. Moreover, review by this Court would resolve a multi-circuit divergence regarding the applicability of *contra proferentem* under ERISA, an issue that affects tens of millions of Americans covered by ERISA insurance plans.

IX. REASONS FOR GRANTING THE WRIT

A. Introduction

Contra proferentem applies without question to state and other insurance policies. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 538-39 (9th Cir. 1990), *cert. denied*, 498 U.S. 1013 (1990), *reh'g denied*, 498 U.S. 1074 (1991). The issue presented here is whether this long-standing constructional tool applies to ERISA insurance policies. The United States

Courts of Appeal are irreconcilably split on this issue. Moreover, even Courts of Appeal which apply *contra proferentem* to ERISA insurance policies sharply disagree as to whether it applies all the time or only under certain circumstances. The uniformity Congress sought in enacting ERISA does not exist under the current legal landscape. Ms. Winters asks this Court to resolve this circuit split and determine whether and to what extent *contra proferentem* applies to ERISA insurance plans.

B. The United States Circuits Sharply Disagree Regarding Whether and to What Extent *Contra Proferentem* Applies to ERISA Insurance Policies.

With the exception of the Ninth Circuit in *Winters*, all circuits apply

contra proferentem regardless of whether the plan is self-funded. With the exception of the Eighth Circuit, all circuits apply *contra proferentem* to ERISA insurance policies where the plan administrator does *not* have discretion. There is a multi-circuit divergence, however, on whether *contra proferentem* applies where the administrator *has* discretion. This divergence has its genesis in this Court's decision of *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1988).

At issue in *Firestone* was the appropriate standard of review for actions challenging denials of benefits based on plan interpretations. ERISA does not provide a standard of review in the statute. As a result, courts had

been using the arbitrary and capricious standard developed under the Labor Management Relations Act (LMRA). *Firestone, supra,* 489 U.S. at 109. Under this standard, courts defer to the administrator's interpretation unless it is unreasonable. 489 U.S. at 111.

The *Firestone* Court established a tripartite standard of review. Where the administrator has "discretionary authority to determine eligibility for benefits," the arbitrary and capricious standard (also known as the "abuse of discretion" standard) applies. 489 U.S. at 115. Where the administrator has discretionary authority, but operates under a conflict of interest (for example, because it is also the insurer, as in *Winters*), its decision is entitled

to somewhat less deference. *Id.* Where the administrator does not have such discretion, a de novo standard of review applies. *Id.*

After *Firestone,* federal courts began considering whether *contra proferentem* applies to ERISA insurance policies. The Ninth Circuit was the first to squarely address this issue, in the seminal decision of *Kunin v. Benefit Trust Life Ins. Co.,* 910 F.2d 534 (9th Cir. 1990), *cert. denied,* 498 U.S. 1013 (1990), *reh'g denied,* 498 U.S. 1074 (1991). Comment, Mark Traynor, *Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees Under ERISA by Construing Ambiguous Plan Terms Against the Insurer,* 77 Minn. L. Rev. 1219, 1231 (1993). The *Kunin* court "carefully

considered" the *Firestone* decision, and "held that it did not abolish the rule of *contra proferentem* in ERISA cases." 77 Minn. L. Rev. at 1233.

Most circuits generally follow *Kunin*, and thus agree that *contra proferentem* applies to ERISA insurance policies. These circuits maintain that an administrator abuses its discretion by failing to interpret ambiguities in favor of the insured. Some circuits, however, reject application of *contra proferentem* where the standard of review is for abuse of discretion. These circuits believe application of *contra proferentem* is inconsistent with this highly deferential standard of review. The circuits thus are irreconcilably split regarding whether and to what

extent *contra proferentem* applies under ERISA. The following discussion details this circuit split.

1. The Seventh and D.C. Circuits Always Apply *Contra Proferentem*, Regardless of the Insurer's Identity or the Standard of Review.

The Seventh and D.C. Circuits always apply *contra proferentem* to ERISA insurance policies, even where the plan is self-funded and the plan administrator has discretion to interpret ambiguous terms. These Circuits reason that deferring to the administrator is not inconsistent with requiring the administrator to construe ambiguities in favor of the insured. Stated differently, it is an abuse of discretion, given the fiduciary

relationship between the administrator and the insured, to reject an insured's reasonable interpretation of an ambiguous policy term. In addition, the Seventh and D.C. Circuits apply *contra proferentem* to both third-party plans and self-insured plans.

For example, the Seventh Circuit applied *contra proferentem* to a third-party insurance plan under de novo review in *McNeilly v. Bankers United Life Assur. Co.*, 999 F.2d 1199, 1201 (7th Cir. 1993), *Phillips v. Lincoln Natl. Life Ins. Co.*, 978 F.2d 302, 311-12 (7th Cir. 1992), and *Hammond v. Fidelity & Guar. Life Ins. Co.*, 965 F.2d 428, 431 (7th Cir. 1992). *See also Pitcher v. Principal Mut. Life Ins. Co.*, 870 F. Supp. 903, 914 (S.D. Indiana

1994). In *Camelot Care Ctrs., Inc., v. Planters Lifesavers Co.*, 836 F. Supp. 545, 548 (N.D. Ill. 1993), also involving de novo review, *contra proferentem* was applied to a self-funded insurance plan. *Cf. Meredith v. Allsteel, Inc.*, 11 F.3d 1354, 1358 (7th Cir. 1993) (ERISA retirement plan, de novo review). In *Springs Valley Bank & Trust Co. v. Carpenter*, No. NA 91-94-C, 1993 U.S. Dist. LEXIS 20838 at *27 (S.D. Indiana Oct. 1, 1993), *contra proferentem* was applied to a third-party insurance plan under discretionary review. And in *Brewer v. Protexall, Inc.*, 50 F.3d 453 (7th Cir. 1995), also involving discretionary review, the court applied *contra proferentem* to a self-funded plan. 50 F.3d at 457, n8.

The *Brewer* case is particularly pertinent, since it involved the same type of plan and standard of review as in *Winters*.

Brewer began working at Protexall in October 1988. Six months later, he became eligible to enroll in Protexall's health insurance plan. Instead, he opted to retain the coverage he had through his previous employer. That coverage lapsed in June 1989. Brewer obtained temporary coverage through Time Insurance, and then joined the Protexall plan in September 1989. Protexall began deducting premiums from his paycheck at that time.

At the beginning of 1990, Brewer submitted $7986 in health insurance claims. Protexall refused to pay. It argued that Brewer was not covered by

its plan because he never provided proof of his good health when he enrolled. Brewer admitted that he did not provide such proof, but maintained the plan did not require him to do so. He cited a plan provision exempting employees from proving their good health if they "had comparable health coverage elsewhere which terminates. In this case, application for enrollment [could] be made within twenty (20) days of the other coverage termination date without submission of evidence of good health." 50 F.3d at 456.

Protexall responded that this exemption was not in effect when Brewer enrolled in September 1989. Rather, Protexall asserted, the exemption was part of an old plan that had been superseded. The court disagreed. The

new plan had not been executed until November 1990, and thus the twenty-day exemption still was effective when Brewer enrolled in September 1989. *Id.*

Protexall then asserted that Brewer did not qualify for the exemption, because his temporary Time policy was not "comparable . . . coverage." 50 F.3d at 456. The court again held for Brewer. It found that the term "comparable" was ambiguous, "[b]ecause the term is subject to more than one reasonable interpretation and because it is not clarified anywhere in the plan itself." 50 F.3d at 458. Because the term was ambiguous, and "[b]ecause at least one of the reasonable interpretations of 'comparable' include[d] Brewer's temporary policy," the court applied *contra proferentem* and

construed the term in Brewer's favor. *Id.*

The *Brewer* court reviewed the administrator's interpretation with the highest level of deference, because the administrator was a third party and therefore had no conflict of interest. 50 F.3d at 456, n2. *Contra proferentem* applied despite this highly deferential standard of review, the court reasoned, because

> the requirement of deference to a particular party's interpretation is not inconsistent with reliance on presumptions that might favor one or the other party. In other words, even if an administrator has discretion to construe the terms of a plan, the administrator can abuse its discretion by failing to apply the rule that ambiguities must be resolved in favor of the insured.

50 F.3d at 457, n8.

The District Court for the District of Columbia applied the same rationale to a self-funded ERISA insurance plan in *Germany v. Operating Engrs. Trust Fund of Washington, D.C.*, 789 F. Supp. 1165 (D.C. 1992). As in the *Brewer* case, the *Germany* court applied a highly deferential standard of review. 789 F. Supp. at 1167. Nevertheless, the court held, it is not inconsistent to defer to one party's interpretation yet apply a presumption in favor of another party. 789 F. Supp. at 1170. Therefore, "deference to an administrator's interpretation does not trump the long-standing rule of construction that ambiguities are resolved in favor of the insured." 789 F. Supp. at 1170.

2. The Fourth and Eleventh Circuits Always Apply *Contra Proferentem* Under De Novo Review, and Apply it Under Discretionary Review if the Administrator Suffers a Conflict of Interest.

The Fourth and Eleventh Circuits always apply *contra proferentem* under de novo review, and apply it under discretionary review if the administrator suffers a conflict of interest. These circuits have not addressed the applicability of *contra proferentem* under the highly deferential, arbitrary and capricious standard of review.

The Fourth Circuit first applied *contra proferentem* in *Glocker v. W.R. Grace & Co.*, 974 F.2d 540 (4th Cir. 1992). In *Glocker*, review was de novo

and the plan was not self-funded. Soon after *Glocker*, the Fourth Circuit applied *contra proferentem* under discretionary review, in *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80 (4th Cir. 1993), and in *Foster v. State Farm Mutual Ins. Plan*, 843 F. Supp. 89 (W.D.N.C. 1994). The *Doe* and *Foster* courts applied the lower level of deference, however, because the defendants in those cases operated under a conflict of interest. 3 F.3d at 87. The Fourth Circuit has not yet considered whether *contra proferentem* applies where there is no conflict of interest.

In *Doe*, the insured was diagnosed with blood cancer. Treatment required high doses of chemotherapy, which is

harmful to bone marrow. To avoid destruction of the patient's bone marrow, doctors prescribed an autologous bone marrow transplant. In this procedure, marrow is removed temporarily from the body and replaced after high-dose chemotherapy is completed. The insurance contract expressly covered chemotherapy; excluded, however, were transplants or "services . . . related to" transplants. 3 F.3d at 88.

Blue Cross argued this provision excluded coverage for *high*-dose chemotherapy, because "without the autologous bone marrow transplant, the high-dose chemotherapy could not be performed." *Id.* The court, relying on the principle of *contra proferentem,* held for the insured. It reasoned that

"in the absence of clear language, [the exclusion could not] be construed to withdraw coverage [that was] explicitly granted elsewhere in the contract." *Id.* Since the policy explicitly granted chemotherapy coverage, such coverage could not be withdrawn under the transplant exclusion.

The plan involved in *Doe* was not self insured. A Fourth Circuit district court, however, recently applied *contra proferentem* to a self-insured, discretionary plan in *Foster v. State Farm Mutual Insurance Plan,* 843 F. Supp. 89 (W.D.N.C. 1994). As in *Doe*, the court reviewed the administrator's decision under the arbitrary and capricious standard, but gave it less deference since the administrator

operated under a conflict of interest. 843 F. Supp. at 93.

The Eleventh Circuit, also recognizing that an administrator's conflict of interest affects the standard of review, has developed a unique, five-step plan interpretation process involving application of *contra proferentem*.

> First, a court must establish whether the claimant has proposed a "reasonable" interpretation of the plan under which he could be covered. If the plan grants the claims administrator discretion to interpret disputed provisions, however, the next step is to consider whether the claims administrator's interpretation was arbitrary and capricious. If the claimant has established a reasonable interpretation, then under contra proferentem, . . . the claimant's interpretation is taken as correct. Where no conflict of interest is present, a claims administrator's wrong but

> reasonable interpretation will not be found arbitrary and capricious. However, if a conflict of interest is established, the burden shifts to the administrator to prove that his or her interpretation of the plan was not tainted by self-interest.

Florence Nightingale Nursing Serv. v. Blue Cross/Blue Shield of Alabama, 41 F.3d 1476, 1481 (11th Cir. 1995) (self-funded plan), *cert. denied,* 115 S.Ct. 2002 (1995). *Accord, Lee v. Blue Cross/Blue Shield of Alabama,* 10 F.3d 1547, 1550 (11th Cir. 1994) (not self-funded); *Reed v. American Express Co.,* 863 F. Supp. 1572, 1576 (S.D. Fla. 1994) (self-funded); *Calhoun v. Complete Health Clinic,* 860 F. Supp. 1494, 1498 (S.D. Alabama 1994) (not self-funded). "[O]ne way an [administrator can] purge the taint of self-interest [is to]

prov[e] that its interpretation of its policy is calculated to maximize the benefits available to the plan participants and beneficiaries at a cost that the plan sponsor can afford." *Calhoun, supra,* 860 F. Supp. at 1500. Whether the plan is self-funded is not relevant to this five-step analysis.

For example, consider *Calhoun v. Complete Health Inc., supra.* Calhoun was a thirty-year-old woman with an aggressive form of breast cancer. Despite chemotherapy and a mastectomy, Calhoun's cancer persisted. Her doctor therefore recommended high-dose chemotherapy coupled with an autologous bone marrow transplant. Without this treatment, Calhoun's chance of survival was less than ten percent; with the

treatment, Calhoun's odds would be increased to greater than fifty percent. 860 F. Supp. at 1496, n4.

Complete Health denied preadmission approval for this treatment. It conceded Calhoun's chemotherapy was covered; it asserted, however, that the bone marrow transplant was excluded. Thus, Calhoun could have the chemotherapy, but not the transplant. Calhoun responded that Complete Health's interpretation completely eviscerated her chemotherapy coverage, because without the transplant, the chemotherapy would destroy her bone marrow, and thus kill her.

Following the Eleventh Circuit's five-step analysis, the court first considered whether Calhoun's interpretation of the plan was

reasonable. It determined that, because the transplant "is the support which makes high dose chemotherapy possible and, therefore, is part and parcel of the chemotherapy treatment," the scope of coverage was ambiguous. 860 F. Supp. at 1498. Therefore, *contra proferentem* applied, and dictated that the policy be interpreted in Calhoun's favor. 860 F. Supp. at 1499.

The next step was to determine the amount of deference to give Complete Health's interpretation. Complete Health had discretion to interpret plan provisions; however, it suffered from a conflict of interest, since it was both the insurer and the administrator. 860 F. Supp. at 1498. The burden thus shifted to Complete Health to prove its interpretation was not tainted by self-

interest. Complete Health did not satisfy this burden. The court therefore applied the less deferential standard of review, and found Complete Health's interpretation arbitrary and capricious.

First, the court determined that Complete Health "should not be allowed to deny coverage based on plan limitations which do not clearly and explicitly exclude that treatment." 860 F. Supp. at 1501. Second, the court found the administrator's decision making process was arbitrary and capricious.

> The only policy provision [the administrator] considered was that provision which excluded transplants. It appears that the sole issue . . . considered was whether or not [the high-dose chemotherapy and autologous bone marrow transplant] was a transplant and that no consideration was given

> to the contracts' chemotherapy . . . coverage."

860 F. Supp. at 1501. Calhoun's treatment therefore was covered.

3. The Second and Sixth Circuits Apply *Contra Proferentem*, but Only Under De Novo Review.

The Second and Sixth Circuits apply *contra proferentem* only where review is de novo. Unlike the Fourth, Seventh, Eleventh and D.C. Circuits, they believe *contra proferentem* is inconsistent with a deferential standard of review. These courts accord no significance to the insurer's identity, and thus apply *contra proferentem* to both third-party plans and self-insured plans.

The Second Circuit first applied *contra proferentem* in *Masella v. Blue Cross & Blue Shield of Connecticut*, 936

F.2d 98 (2d Cir. 1991). The standard of review was de novo. Blue Cross, the third-party insurer, refused to pay for the non-surgical treatment of Masella's temporomandibular joint dysfunction (TMJ). Blue Cross argued the treatment was "dental" rather than "medical" in nature, and therefore was excluded from coverage.

TMJ is a dysfunction of the temporomandibular joint rather than the teeth. "[C]ommonly used treatments for TMJ such as the . . . treatment given to Masella are similar to the treatment of joint problems elsewhere in the body and are primarily medical in nature." 936 F.2d at 105.

Nevertheless, Blue Cross contended that the "dental" exclusion referred to "'non-surgical services primarily

performed by dentists,' apparently without regard to whether or not the services relate to the teeth." 936 F.2d at 106. The court disagreed, holding that the "dental" exclusion "is defined by the nature of the procedure performed rather than by the title of the one who performs it." *Id.* Moreover, the court held, the principle of *contra proferentem* dictated the same result. 936 F.2d at 107. *Cf. Kascewicz v. Citibank, N.A.*, 837 F. Supp. 1312, 1318 (S.D.N.Y. 1993) (de novo review, ERISA retirement plan).

The Second Circuit did not consider the applicability of *contra proferentem* under arbitrary and capricious review until 1995, in the unpublished disposition of *Pagan v. Plan,* No. 94-

7344, 1995 U.S. App. LEXIS 8460 (2d Cir. Apr. 12, 1995). *Pagan* involved an employer-funded plan where the employer, NYNEX, had retained discretion to interpret the plan. The court noted NYNEX's potential conflict of interest, 1995 U.S. App. LEXIS 8460 at *12-13, but accorded no other significance to the plan's self-funded nature. Rather, it refused to apply *contra proferentem* on the ground that it is inapplicable under "the highly deferential arbitrary and capricious standard of review." 1995 U.S. App. LEXIS 8460 at *17.

Because *contra proferentem* did not apply, the court held that the plaintiff-insured could no longer collect disability payments for an injury allegedly sustained in an

automobile accident and for an asthmatic condition aggravated by smoking co-workers. Moreover, the court held, coverage was inappropriate since the insured could not prove she actually was injured in the automobile accident, and her office now was smoke free. 1995 U.S. App. LEXIS 8460 at *5-6. *Cf. O'Neil v. Retirement Plan for Sal. Empl. of RKO,* 37 F.3d 55, 61 (2d Cir. 1992) (arbitrary and capricious review, ERISA retirement plan).

The Sixth Circuit Court of Appeals has determined *contra proferentem* applies where review is de novo. *See Tolley v. Commercial Life Ins. Co.,* Nos. 92-6490, 92-6514, 1993 U.S. App. LEXIS 33508 at *6-7 (6th Cir. Dec. 17, 1993). It has not determined whether *contra*

proferentem applies under arbitrary and capricious review. The district court has done so, however, in *McDuffey v. Michigan Conf.*, 872 F. Supp. 402 (E.D. Mich. 1994). *McDuffey* involved an ERISA insurance plan that was the product of collective bargaining: the employees' union and the employer negotiated the plan terms.

McDuffey sought disability compensation. He had been injured in October, 1991. This injury necessitated amputation of his foot in June, 1992. Under the terms of the plan, "plaintiff was entitled to $10,000 if he suffered a 'loss' within 90 days after an accident. The plan defined the term 'loss' to mean 'severance.'" 872 F. Supp. at 409. Plaintiff argued these plan terms were

ambiguous, and that *contra proferentem* therefore applied.

The court, however, found that *contra proferentem* did *not* apply, because the standard of review was arbitrary and capricious, and the administrator's interpretation was rational. *Id.* Moreover, the plan was not ambiguous; since the plaintiff's severance occurred more than 90 days after an accident, his loss clearly was not covered. *Id.* And finally, the court held, *contra proferentem* "does not apply to plans that result from a collective bargaining agreement," because the rationale for its application – protecting an insured from terms he has been forced to accept on a take-it-or-leave-it basis – does not

exist in such situations. *Id.* *See also* *Eley v. Boeing Co.*, 945 F.2d 276, 279-80 (9th Cir. 1991). Rather, where the plan results from collective bargaining, the employee's union protects his interests during the bargaining process. *But see* *Camelot Care Centers, Inc. v. Planters Lifesavers Co.*, 836 F. Supp. 545, 549 (N.D. Ill. 1993) (even where the plan is the result of collective bargaining, "an insured participant . . . surely ha[s] no role . . . in the [bargaining] process. As between such an insured and the insurer, the doctrine [of *contra proferentem*] must apply with full vigor").

4. The Eighth Circuit Maintains that ERISA Preempts Application of *Contra Proferentem*, yet Applies *Contra Proferentem* when Other Constructional Tools are Unavailing.

Several Eighth Circuit decisions maintain that ERISA preempts application of *contra proferentem*, regardless of the insurer's identity or the standard of review. *See, e.g., Maxa v. John Alden Life Ins. Co.*, 972 F.2d 980, 985 (8th Cir. 1992) (de novo review, not self-insured), *cert. denied*, 113 S.Ct. 1048 (1993); *Finley v. Special Agents Mut. Ben. Assn., Inc.*, 957 F.2d 617, 619 (8th Cir. 1992) (de novo review, not self-insured); *Brewer v. Lincoln Natl. Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990) (de novo review, not self-

insured), *cert. denied,* 501 U.S. 1238 (1991). In *Delk v. Durham Life Ins. Co.*, 959 F.2d 104 (8th Cir. 1992), however, the Eighth Circuit distinguished such decisions and applied *contra proferentem* to a self-funded ERISA insurance policy under de novo review. The *Delk* court held that in its other decisions, specifically *Brewer, supra,* resort to *contra proferentem* was not necessary because the language at issue was unambiguous. 959 F.2d at 105. Rather, the *Brewer* language was ambiguous only if accorded a specialized, as opposed to an ordinary, meaning. In the *Delk* case, in contrast, "the language remain[ed] ambiguous even after applying the approach in *Brewer.*" *Id.* Therefore, resort to *contra*

proferentem was appropriate since other constructional tools failed to cure the ambiguity.

5. Under *Winters*, the Ninth Circuit Applies *Contra Proferentem* Unless the Plan is Self-Funded and the Administrator has Discretion to Interpret Ambiguities.

The Ninth Circuit first considered *contra proferentem* in the seminal case of *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990), *cert. denied*, 498 U.S. 1013 (1990), *reh'g denied*, 498 U.S. 1074 (1991). Kunin and his family participated in a group health insurance policy issued to Kunin's employer by the Benefit Trust Life Insurance Company. Kunin incurred over $50,000 in medical bills for his

son's treatment for autism. Benefit Trust refused to pay $40,000 of these bills, arguing that Kunin's policy capped benefits for "mental illness or nervous disorders" at $10,000 per year. 910 F.2d at 535. The district court found that autism is not a mental illness, and that therefore the denial of benefits was arbitrary and capricious under the pre-*Firestone*, LMRA standard of review. 910 F.2d at 536. It ordered Benefit Trust to pay the claim in full. Benefit Trust appealed.

The court of appeals first determined the appropriate standard of review. *Firestone* had been promulgated in the interim, establishing the tripartite standard of review. For its analysis, the court applied the arbitrary and capricious standard, even

though Benefit Trust did not have the contractual discretion to interpret the plan. 910 F.2d at 537.

Next the court applied this standard to Benefit Trust's interpretation of "mental illness." Benefit Trust determined autism was a mental illness on the recommendation of Dr. Zolot, Benefit Trust's medical director. Dr. Zolot based his recommendation on "informal conversations with three psychiatrists, whose experience with autism [was] unknown, and . . . a textbook definition of autism." 910 F.2d at 535.

The court called Dr. Zolot's investigation an "altogether inadequate basis for determining autism to be a mental illness." 910 F.2d at 537-38. First,

> [t]he record [did] not indicate that the doctors with whom the medical director consulted had any significant experience with or particular expertise concerning autism. Moreover, the director made no effort to discuss the matter with [Kunin's son's] physicians, who later unequivocally testified that autism is not a mental illness. Additionally, the textbook definition Dr. Zolot relied on state[d] that although autism was previously thought to be "primarily psychiatric, it is now thought to be organically based." On its face, this definition contain[ed] no conclusions about whether autism should be classified as a mental illness. If anything, the fact that autism is no longer considered "primarily psychiatric" suggests that autism is not a mental illness.

910 F.2d at 539. The evidence adduced at trial confirmed the court's decision. Benefit Trust's denial of benefits therefore was arbitrary and capricious.

The court then held, in the alternative, that the term "mental illness" was ambiguous. It was not clear whether "mental illness" included autism, and the policy contained no definition or explanation the term even though it has "no precise or generally accepted definition." 910 F.2d at 541. Therefore, the term was construed in Kunin's favor under the doctrine of *contra proferentem*.

Benefit Trust countered that application of *contra proferentem* is inconsistent with *Firestone's* requirement of deference to the administrator's interpretation. The court disagreed, and held *contra proferentem* applicable even under an arbitrary and capricious standard of

review. It explained that Benefit Trust had

> misread *Firestone* because [it] failed to distinguish between (1) using certain presumptions, including presumptions in favor of a party, in order to arrive at the correct interpretation, and (2) deferring to a particular party's interpretation. Rejecting (2) obviously does not undermine the soundness of (1). We might say, for example, that a jury should not defer to a defendant's plea of "not guilty" – we want the jury to determine his guilt or innocence de novo. However, this in no way implies that the jury, in making this determination, is not required to presume innocence – and indeed, to presume it quite strongly. Again, we might say that a baseball umpire should not defer to a baserunner's claim that he is safe; but this proposition is fully consistent with the separate rule that ties go to the runner. Likewise, while we may not defer to an insured's construction, we must not fail to indulge in a presumption that ambiguous language favors the insured.

910 F.2d at 541.

The Ninth Circuit's next decision involving the application of *contra proferentem* decision was *Eley v. Boeing Co.*, 945 F.2d 276 (9th Cir. 1991). Eley participated in Boeing's self-funded ERISA health benefits plan. This plan was provided pursuant to collective bargaining agreements between Boeing and its employees. 945 F.2d at 277. King County Medical Blue Shield was the plan administrator.[1] As Blue Shield had

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[1] The court did not decide whether Boeing could negate its conflict of interest by hiring a third-party claims administrator, determining that Boeing would prevail even under the less

discretionary authority to interpret the plan, the court applied the arbitrary and capricious standard of review. 945 F.2d at 278.

Shortly before Eley became covered under Boeing's health plan, she had a Pap test. The test results suggested Eley had cervical cancer. Shortly after she became covered under the plan, Eley had a biopsy confirming she had cancer. The cancer necessitated a hysterectomy, and Eley sought reimbursement for the cost of the operation.

Blue Shield denied her claim, arguing that Eley's cancer fell within the policy's preexisting condition exclusion. The plan defined

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deferential, conflict of interest standard of review.

"preexisting condition" as "any illness . . . whether or not diagnosed, for which a person has received . . . a diagnostic test . . . during the three-month period before his or her coverage becomes effective." 945 F.2d at 279. Blue Shield interpreted "diagnostic test" to include Pap tests. *Id.* Eley argued that the term "diagnostic test" was ambiguous. She posited that "screening tests like the Pap test indicate the absence of disease while a diagnosis is defined as 'the art or act of recognizing the presence of disease.'" *Id.*

The court, however, held for Blue Shield, reasoning that although Pap tests technically detect the absence of disease, they are used to "recognize . . . the possible presence

of disease, therefore fitting within the definition of diagnosis." 945 F.2d at 279. Blue Shield's definition of "diagnostic test" therefore did not conflict with the plain language of the plan, and thus was not arbitrary and capricious. Moreover, because the term was not ambiguous, *contra proferentem* did not apply.

The court then listed several other reasons why *contra proferentem* did not apply. First, Boeing's plan, "unlike that in *Kunin,* [was] the result of a collective bargaining agreement." *Id.* Thus, the rationale for *contra proferentem* – to protect employees from an employer/insured who has had exclusive control of the drafting process and the take-it-or-leave-it

nature of the insurance relationship – was inapplicable. *But see Camelot Care Centers, Inc. v. Planters Lifesavers Co.*, 836 F. Supp. 545, 549 n5 (N.D. Ill. 1993) (even where the plan is the result of collective bargaining, "an insured participant . . . surely ha[s] no role . . . in the [bargaining] process. As between such an insured and the insurer, the doctrine [of *contra proferentem*] must apply with full vigor").

Second, Boeing's plan was self-funded. The court did not explain why it considered this relevant. It merely cited a Third Circuit case, *Taylor v. Continental Group Change in Control Severance Pay Plan*, 933 F.2d 1227 (3d Cir. 1991). *Taylor* involved application

of *contra proferentem* to an ERISA *severance pay* plan, as opposed to an ERISA *insurance* plan. When interpreting a *severance pay* plan, the court held, "a district court should attempt to determine its intended meaning without construing it in favor of any party. Only if this factual inquiry proves fruitless should a court resort to constructions in favor of one party or another." 933 F.2d at 1233. The *Taylor* court, noting that *contra proferentem* is "often strictly applied" in the insurance context, expressly *declined* to consider whether *contra proferentem* applied to ERISA *insurance* plans. *Id.* The Third Circuit later determined that it does. *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249 (3d Cir. 1993).

The Ninth Circuit panel in *Winters v. Costco* built upon the *Eley* court's dicta and its misreading of *Taylor*. 49 F.3d 550 (9th Cir. 1995). Unlike *Kunin* and *Eley*, the *Winters* panel applied *Firestone's* middle standard of review: Costco, the employer, was also the plan administrator, so although it had discretionary authority to interpret the plan, it also had a conflict of interest, and therefore was not entitled to the highest level of deference. 49 F.3d at 552-53.

The panel first determined that Costco's interpretation of "in vitro" was not arbitrary and capricious because it did not "clearly conflict with the plain language of the plan." 49 F.3d at 553. The panel did not consider whether

Costco's investigation to determine the meaning of "in vitro" was arbitrary and capricious, even though the *Kunin* court expressly found arbitrary and capricious an investigation that was identical to Costco's investigation. Instead, the panel held that "[t]he abuse of discretion standard permits the district court to review only the evidence presented to the plan trustees." *Id.*

The panel then determined that the district court's application of *contra proferentem* was inappropriate. Relying on *Eley,* the panel declared that *contra proferentem* does not apply where the ERISA plan "(1) was the result of collective bargaining, and (2) was self-funded." 49 F.3d at 554. Here, the court reasoned, although the plan was

not the result of collective bargaining, it was self-funded, so *contra proferentem* did not apply. *Id.* Moreover, the panel declared, it is not proper to use *contra proferentem* where, as here, the plan grants the administrator discretion to interpret the plan. *Id.* To summarize, the panel stated, *contra proferentem* "is not applicable to self-funded ERISA plans that bestow explicit discretionary authority upon an administrator to determine eligibility for benefits or to construe the terms of the plan." 49 F.3d at 554.

It is not clear after *Winters* whether *contra proferentem* applies to self-funded plans that do *not* grant discretion to the administrator. Nor is

it clear what impact *Winters* has on *Kunin's* holding that *contra proferentem* applies under arbitrary and capricious review. ERISA law in the Ninth Circuit thus is uncertain. Employers do not know if adopting a self-funded plan is in their best interest, and employees do not know if avoiding a self-funded plan is in their best interest. Moreover, employees do not know if they can rely on the purported coverage of an insurance policy that grants discretion to the plan administrator.

6. The Four Remaining Circuits Apply *Contra Proferentem* Where Review is De Novo, but have not yet Considered Whether to Apply it Where Review is for Abuse of Discretion or Where the Plan is Self-Funded.

The First, Third, Fifth and Tenth Circuits remain. These circuits apply *contra proferentem* where review is de novo. None accords significance to the insurer's identity. All have yet to consider whether *contra proferentem* applies where review is for abuse of discretion.

In the First Circuit, *see Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264 (1st Cir. 1994) (de novo, not self-insured). *But cf. Allen v. Adage*, 967 F.2d 695 (1st Cir. 1992) (*contra proferentem* does not apply to ERISA severance pay plan).

In the Third Circuit, *see Heasley v. Belden & Blake Corp.*, 2 F.3d 1249 (3d Cir. 1993) (self-funded plan, applying *contra proferentem* to determine whether

plan granted discretionary authority to administrator, held, administrator had no discretion, therefore de novo review appropriate).

In the Fifth Circuit, *see Todd v. AIG Life Ins. Co.*, 47 F.3d 1448 (5th Cir. 1995) (de novo, not self-funded); *Ramsey v. Colonial Life Ins. Co. of America*, 12 F.3d 472 (5th Cir. 1994) (de novo, not self-funded); *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991) (de novo, not self-funded). *But see Nettie Chauvin v. Texas Instruments, Inc.*, No. 91-2445, 1992 U.S. Dist. LEXIS 13683 at *9-10 (E.D. La. Sept. 9, 1992) (*contra proferentem* inapplicable to ERISA insurance plan); *Chambers v. Prudential Ins. Co. of America*, 776 F. Supp. 1166, 1169 (S.D.

Miss. 1991) (same), *aff'd*, 947 F.2d 1487.

And in the Tenth Circuit, *see Blair v. Metropolitan Life Ins. Co.*, 974 F.2d 1219, 1222 (10th Cir. 1992) (de novo, not self-insured, interpreting an ERISA insurance policy in the insured's favor without resort to *contra proferentem* and without deciding whether it applies under ERISA, but rather on the basis of "basic trust principles that protect . . . the interests of the beneficiary-employee").

C. Failure to Apply *Contra Proferentem* to ERISA Insurance Policies Would Enable an Employer to Lull Employees with an Illusory Promise of Broad Coverage, Thereby Contravening the Legislature's Purpose, in Enacting ERISA, to Protect Employees from such Abuses.

There is a great need to protect insureds where the ERISA insurance policy is self-funded and the employer has retained discretion to interpret coverage ambiguities. Self-funded ERISA policies are drafted by employers; where such employers give themselves discretion to interpret coverage ambiguities, failure to apply *contra proferentem* creates a powerful incentive for some employers to draft ambiguous insurance policies. *Cf. Eley v. Boeing Co.*, 945 F.2d 276, 279 (9th Cir. 1991) ("if the employer is the administrator, a conflict [of interest] ordinarily exists"). This is because an employer can draft an ambiguous policy, and then at claim time construe ambiguities against coverage. Since employees may

interpret ambiguities broadly, and therefore not realize the limits of their coverage, their ability to accurately compare job alternatives is impaired. Thus, an employer's market incentive to provide competitive coverage disappears. In effect, employers have their cake and eat it too: they can lure quality employees with the promise of employer-provided insurance, yet avoid the cost of competitive insurance coverage. This result contravenes the remedial, protective purposes behind ERISA's enactment. *See Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98, 107 (2d Cir. 1991). *See also Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1257 (3d Cir. 1993); *Phillips v.*

Lincoln Natl. Life Ins. Co., 978 F.2d 302, 312-13 (7th Cir. 1992); *Everson v. Blue Cross & Blue Shield of Ohio*, No. 93CV7534, 1994 U.S. Dist. LEXIS 14754 at *14 (N.D. Ohio June 15, 1994), quoting *Masella, supra*. *Cf. Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1988); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); 29 U.S.C. § 1001.

X. CONCLUSION

The *Winters* panel's failure to apply *contra proferentem* to a self-funded ERISA insurance policy where review is for abuse of discretion is contrary to state and other insurance law, the policies underlying ERISA, and the decisions of other Circuit courts.

Failure to apply *contra proferentem* is contrary to state and other insurance law because *contra proferentem* applies in all states, without question, to insurance policies which are not covered by ERISA.

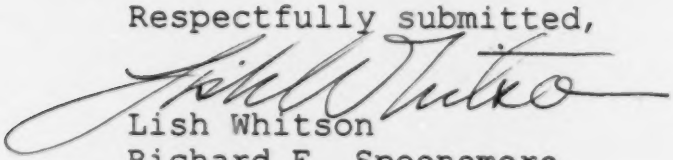
Failure to apply *contra proferentem* to ERISA insurance policies also violates the remedial, protective purpose of ERISA because such failure encourages ambiguous drafting. This is particularly true where the plan is self-funded, the employer is the drafter, and judicial review is based on abuse of discretion. In this situation, a certain kind of employer has a powerful incentive to draft policies as ambiguously as possible and thus lull employees with the illusory promise of

coverage. The promise is illusory because such an employer can construe ambiguities against coverage at claim time. Moreover, the employee is not able to protect himself or herself from limited coverage, because the employee is likely to assume ambiguities will be construed in the employee's favor. The employer thus has no market incentive to provide competitive insurance coverage.

Finally, the *Winters* panel's decision is contrary to decisions of other circuits. No other circuit accords significance to the identity of the insurer. Moreover, the circuits do not agree that *contra proferentem* is inapplicable where review is for abuse of discretion. Rather, two circuits apply *contra proferentem* regardless of

the standard of review; two circuits apply *contra proferentem* where the administrator suffers a conflict of interest; two other circuits apply *contra proferentem* only where review is de novo; one maintains that ERISA preempts *contra proferentem;* and the remaining circuits are undecided. This Court therefore should grant the petition for review to resolve the circuit split and determine whether and to what extent *contra proferentem* applies to ERISA insurance policies.

Respectfully submitted,



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FILED

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NO.

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1995

DONNA WINTERS, an individual person,

Petitioners,

v.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM and CONCEPT ADMINISTRATORS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, NINTH CIRCUIT

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DONNA COLE WINTERS,	)	
	)	
Plaintiff-	)	
Appellee,	)	No. 93-35851
	)	
v.	)	D.C. No.
	)	CV-92-00581-
COSTCO WHOLESALE	)	WLD
CORPORATION,	)	
a Washington	)	OPINION
corporation;	)	
CONCEPT ADMINISTRATORS,	)	
INC., a California	)	
corporation,	)	
	)	
Defendants-	)	
Appellants.	)	

Appeal from the United States District Court
for the Western District of Washington
William L. Dwyer, District Judge, Presiding

Argued and Submitted
October 5, 1994--Seattle, Washington

Filed March 6, 1995

Before: Donald P. Lay,* Stephen S. Trott

and Thomas G. Nelson, Circuit Judges

Opinion by Judge T.G. Nelson

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*Honorable Donald P. Lay, Senior United States Circuit Judge for the Eighth Circuit, sitting by designation.

SUMMARY

Labor and Employment/Health Care Coverage/ERISA

The court of appeals reversed a district court judgment and remanded the court held that an administrator of an Employee Retirement and Income Security Act (ERISA) health benefit plan did not abuse its discretion in denying a claim for benefit relating to a gamete intrafallopian transfer (GIFT) procedure as an excluded charge in connection with "in-vitro" fertilization.

As an employee of appellant Costco Wholesale Corp., appellee Donna Winters participated in the company's self-insured ERISA health benefit plan. the plan excluded charges "not reasonably

necessary for the diagnosis and treatment of Illness or Injury." the plan also excluded from coverage charges "in connection with in vitro fertilization" (IVF) plan provides that the plan's administrator has absolute discretion and authority to construe disputed or seemingly inconsistent plan provisions and to make all decisions regarding eligibility and/or entitlement to coverage or benefits.

Winters filed a claim ft reimbursement of expenses related m a gift procedure. the gift procedure involves retrieving eggs from the patient's ovaries and placing the eggs, along with sperm, in the patient's fallopian tube. Winters' claim was denied by appellant Con-

cept Administrators. Inc., Costco's third-party claims administrator, as a charge in connection with in-vitro fertilization. the denial was affirmed by Costco with advice from a consulting firm to health benefits providers.

Winters sued the plan and the plan administrator (collectively, Costco), challenging the denial of benefits. The district court granted Winters summary judgment under ERISA. determining that she was entitled to reimbursement for the

expenses of the GIFT procedure. the court concluded that the administrator's decision conflicted with the 'plain and ordinary meaning' of IVF and therefore, constituted an abuse of discretion. Alternatively, the court stated that if the plain an ordinary meanings of IVF and GIFT were not used, the plan's term "IVF" would have to be deemed ambiguous; the court observed that the rule of *contra proferentem* would result t the ambiguity being resolved in Winters' favor. Costco appealed.

[1] Where an ERISA plan vest the administrator with discretionary authority to determine benefit eligibility, the district court can review the administrator's determination only for abuse

of discretion. [2] In this case. however, because the administrator was the employer, a more stringent version I the abuse of discretion standard applied to Costco's decision to deny Winters health benefits.

[3] In evaluating Winters' claim, the administrator relied on a statement of a consulting physician that gift involves combining eggs with sperm "in vitro." 1he administrator alt reviewed Winters' medical records which characterized her procedure as "in vitro," [4] Thus, it could not be said that the interpretation given to "in vitro" by Costco clearly conflicted with the plain language of the plan. Based on the evidence in the administrative record

Costco's interpretation was not unreasonable. The district court erred in second-guessing the exercise of discretion, because there was no abuse of that discretion.

[5] There was no reason why the heightened abuse of discretion review would change the result in this case. Even if Costco had an interest in broadly construing the in vitro exclusion. there were no indications that the conflict had a impact on the decision to deny benefits.

[6] The rule of *contra proferentem* is not applicable to self-funded ERISA plans that bestow explicit discretionary

authority upon an administrator to determine eligibility for benefit or to construe the terms of the plan.

[7] Winters had no objectively reasonable expectation of coverage for the GIFT procedure.

[8] The district court was instructed on remand to enter judgment in favor of Costco.

COUNSEL

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OPINION

T.G. NELSON, Circuit Judge:

Costco Wholesale Group Benefits Program (the "Plan") and Concept Administrators, Inc. (the "Plan Administrator"), appeal the district court's summary judgment in favor of Donna Cole Winters in her action seeking reimbursement from the Plan for medical expenses related to a gamete intrafallopian transfer ("GIFT") procedure. the Plan is an employee welfare benefit plan subject to regulation under the Employee Retirement Income Security Act cf 1974 ("'ERISA"), 29 U.S.C. s 1001. et seq. We reverse and remand.

I.

FACTS AND PRIOR PROCEEDINGS

As a Costco employee, Winters was a participant in the company's self-insured ERISA health benefits plan. Winter: filed a timely claim for reimbursement of expenses related to a GIFT procedure performed on December 17, 1990. The procedure involves retrieving eggs from the patient's ovaries and placing the eggs, along with sperm, in the patient's fallopian tube.

Section 6.8 of the health plan excludes "[c]harges not reasonably necessary for the diagnosis and treatment of Illness or Injury." Section 6.31 of the plan excludes from coverage "[[C]harges in connection with in-vitro fertiliza-

tion." There i no mention of Gift procedures. Section 14.9 provides that [t]he Plan Administrator ha[s] the absolute discretion an authority to construe disputed or seemingly inconsistent provisions of the Plan and to make all decisions regarding eligibility and/or entitlement to coverage or benefit."

Winters' claim was denied by Concept Administrators Inc.. Costco's third-party claims administrator, as a charge connection with in-vitro fertilization. The denial was affirmed by Costco[1] with advice from Ethix North-

[1] The Costco Wholesale Group Benefits Committee is the Plan Administrator within the meaning of section 3(16)(A) of ERISA, 29 U.S.C. § 1002(16)(A). Concept Administrators acts as an agent of the Plan Administrator under an agreement with Costco and is responsible for processing claims for Plan benefits. Concept's decisions are subject to review by the Plan Administrator.

west, a consulting firm to health benefits providers.

Winters subsequently filed a case against the Plan and the Plan Administrator, challenging the dental of benefits in state court. The defendants removed the case to the district court. Both sides moved for summary judgment The district court granted Winters summary judgment under ERISA determining that she is entitled to reimbursement for the expenses of the gift procedure performed on December 17, 1990.

The court concluded that "[under the "plain and ordinary meaning' of IVF as provided by the dictionary and medical text sources. the administrator's decision cannot stand because it con-

flicts with that meaning and therefore constitutes an abuse of discretion. GIFT, unlike IVF, involves in vivo - specifically, intrafallopian - fertilization of the egg." (Emphasis added-) the court found it unnecessary to address Winters' argument that the standard of review should be less deferential in view of the Plan Administrator's conflict of interest because Winters "prevail[s] even under the more deferential abuse of discretion standard"

Alternatively, the court explained that "[i]f the 'plain and ordinary meaning' of IVF and GIFT set out above were not used, then "IVF' - the term used in the plan - would have to be deemed ambiguous." Nothing that defendants' own

expert testified in his deposition that the policy "may be ambiguous" with respect to the gift procedure and that this could create confusion, the court observed that the rule of *contra proferentem* would result in the ambiguity being resolved in winters' favor. The Plan and the Plan Administrator (collectively referred to as "Costco") timely appeal.

II.

STANDARD OF REVIEW

[1] Where an ERISA plan vests the administrator with discretionary authority to determine benefit eligibility. "a district court may review the administrator's determinations only for an abuse of discretion." *Taft v. Equitable Life Assurance*

Soc'y, 9 F.3d 1469, 1471 (9th Cir. 1993) (citing *Firestone Tire & Rubber Co. v.* Bruch, 489 U.S. 101, 115 (1989)). This court reviews the district court's application of this standard and the conclusion that Costco abused its discretion de novo. *Id.*

[2] In this case the Plan Administrator is the employer. Therefore, this court "impose[s] a more *stringent* version of the abuse of discretion standard" to Costco's decision to deny Winters health benefits. *Id.* at 1474 (internal quotation omitted). This court reviews *de novo* whether the plan's terms are ambiguous. *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948,

950 (9th Cir. 1993); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 537 (9th Cir.,) *cert.* denied, 498 U.S. 1013 (1990).

III.

DISCUSSION

Costco makes two basic arguments on appeal. First, Costco argues that the district court applied the wrong standard to review the interpretation of the Plan by the Plan Administrator. and should have given deference to the Plan Administrator's interpretation. rather than apply the doctrine of *contra proferentem*. Second, Costco argues that the district court's interpretation of the Plan under *contra proferentem* was not only improper, but

incomplete, because it did not address or consider Plan provisions concerning "covered charges."

Costco contends that while the district court purported to apply an abuse of discretion standard to the Plan Administrator's denial decision, it actually did not accord the decision any deference, and instead substituted its own definition of "in vitro fertilization." Section 14.9 of the Plan expressly grants absolute discretionary authority to the Plan Administrator to "interpret or construe all provisions of the Plan" and "construe disputed or seemingly inconsistent provisions of the Plan and to make all decisions regarding eligi-

bility and/or entitlement to coverage or benefits." This is sufficient to trigger the deferential abuse of discretion standard of review. *See*

Firestone, 489 U.S. at 115; *Eley v. Boeing Co.*, 945 F.2d 276, 278 (9th Cir. 1991). Because the employer is the administrator, a conflict of interest exists. and we therefore "impose a more *stringent* version of the abuse of discretion standard" to Costco's decision. *Taft*, 9 F.3d at 1 474 (internal quotation omitted); *see also Eley*, 945 F.2d at 279.

"[T]he abuse of discretion standard permits the district court to review only the evidence presented to the plan trustees. *Taft*, 9 F.3d at 14-71 (internal quotation and brackets omitted); *see also McKenzie v. General Tel. Co.*, 41 F.3d 1310.1316(9th Cir.1994). Because Costco gave an explanation for

the denial of benefits, the question is whether it abused its discretion in construing provisions of the plan in a way that conflicts with the plain language of the plan. *See Eley*, 945 F.2d at 279.

[3] In evaluating Winters' claim the Plan Administrator relied on a statement of a consulting physician that GIFT consists of surgical removal of eggs from the ovaries of the patient combining the eggs with sperm outside of the patient's body, or "in vitro," and then placement of the same into the patient's fallopian tube. The Plan Administrator also reviewed Winters' medical records from the University of Washington Medical Center which characterized her procedure as "in vitro."

[4] Winters has vigorously maintained and the district court agreed that GIFT and in vitro fertilization are distinguishable. However, this does not necessarily demonstrate that the interpretation given to "in vitro fertilization" by Costco clearly conflicts with the plain language of the Plan See *id.* (not an abuse of discretion to interpret a screening test as a "diagnostic test" and deny benefits on that basis). *In Eley*, the affidavits submitted on behalf of the employer stating that a Pap test is referred to as a diagnostic test by at least some of the medical academic community were not refuted. *Id.* Here, not only did the Plan Administrator's medical consultant

characterize GIFT as involving "in vitro" aspect. Winters' own medical records for the procedure contained "IVF' notations. Thus as in *Eley*, we cannot say that the interpretation given to "in vitro" by Costco clearly conflicts with the plain language of the Plan. *See also Taft*, 9 F.3d at 1473 ("In the ERISA context even decisions directly contrary to evidence in the record do not necessarily amount to an abuse of discretion.") "Our inquiry is not into whose interpretation of the plan documents is most persuasive, but whether the plan administrator's interpretation is unreasonable." *Barnett v. Kaiser Found. Health Plan, Inc.*, 32 F.3d 413, 416 (9th Cir. 1994) (quotation and brackets omitted).

Based on the evidence in the administrative record, Costco's interpretation was not unreasonable. The Plan made clear that the Plan Administrator had the final determination of benefit decisions. the district court erred in second-guessing the exercise of discretion, because there was no abuse of that discretion.

[5] As in *Eley,* the district court did not evaluate Costco's dual role as employer and Plan Administrator. *Taft,* 945 F.2d at 279. "The precise nature of the less deferential review in this context is not clear." *Taft,* 9 F.3d at 1474. However, even if Costco has an interest in broadly construing the in vitro exclusion, there are no indications

that the conflict had an impact on the decision to deny benefits. *See id.* (no evidence that company acted in bad faith or wit improper motives at any time during employee's twenty-five years of employment). We can discern no reason why the heightened abuse of discretion review would change the result in this case. *See id.*; *Taft,* 945 F.2d at 279.

In an alternate ruling. the district court held that the term "in vitro fertilization" was ambiguous, and that the ambiguity should have been resolved in Winters' favor under the rule of *contra proferentem*. *See Kunin,* 910 F.2d at 538-39. In *Kunin,* the court held in the alternative that *contra proferentem* applied in that case, which involved an

ERISA-governed insurance policy by the employer. *Id.* at 539-41.

However, as in *Eley*, *Kunin* does not alter the result in this case. *See Eley*, 945 F.2d at 279-80. *Eley* distinguished *Kunin* on the grounds that the plan in *Eley*, unlike the plan in *Kunin*. (1) was the result of collective bargaining, and (2) was self-funded. Id. at 280. While the Plan at issue here was not the result of collective bargaining, it is self-funded.

[6] Furthermore. it is not proper to rely on this principle of construction where, as here, the Plan grants the fiduciary explicit discretion to interpret the Plan. In *Kunin*, we explained that *contra proferentem* "is based upon the principle of contract construction that when one party is responsible for

the drafting of an instrument, *absent evidence indicating the intention of the parties*, any ambiguity will be resolved against the drafter." *Kunin*, 910 F.2d at 539 (quotation omitted; emphasis added). In contrast the Plan here states that the Plan Administrator has "the absolute discretion and authority to construe disputed or seemingly inconsistent provisions of the Plan and to make all decisions regarding eligibility and/or entitlement to coverage or benefits." The Plan thus states how Plan terms are to be interpreted, and the general rule of *contra proferentem* does not apply. *See O'Neil v. Retirement Plan for Salaried Employees of RKO General, Inc.*, 37 F.3d 55. 61 (2d Cir. 1994) ("We are less

inclined to rely on *contra proferentem*] where, as here, the plan grants the fiduciary discretion to interpret the plan."). We hold that the rule of *contra proferentem* is not applicable to self-funded ERISA plans that bestow explicit discretionary authority upon an administrator to determine eligibility for benefits or to construe the terms of the plan.

In view of our holding, we need not address Costco's argument that the district court's application of *contra proferentem* resulted in the anomalous ruling that GIFT must be covered under the Plan, because it is different than in vitro fertilization. even though the Plan does not include any reproductive

procedures in its "Covered Charges" provisions.

Subsequent to the district court's decision,, we held in *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 387 (9th Cir. 1 994), that the doctrine of reasonable expectations applies as a principal of federal common law controlling interpretation of ERISA-governed insurance contracts. In that case, a group health plan denied liability to a claimant based on a pre-existing condition exclusion. *Id.* at 386. Review of the plan at issue revealed that the plan "chose to bury one of the plan's most significant provisions amidst definitions, rather than forthrightly stating the pre-existing conditions exclusion in

the operative clauses of the plan description." *Id.* at 385. We held that because the plan's attempted exclusion was not clear, plain, and conspicuous enough to negate the claimant's objectively reasonable expectations of coverage, it was unenforceable and the plan was liable for the coverage at issue. *Id.* at 387.

Unlike the claimant in *Saltarelli*, Winters had no objectively reasonable expectation of coverage for the GIFT procedure. Costco made its exclusionary clauses conspicuous, plain and clear. The clauses the exclusionary clauses were listed under an appropriate heading in the Plan table of contents. The exclusions were clearly numbered, placed

under underlined headings, and set off in separate paragraphs. Winters was also notified prior to this medical treatment through two separate letters, that in vitro fertilization procedures were excluded from coverage because they are not medically necessary for treatment of an accidental injury or illness. We agree with Costco that there is no evidence in the record upon which a reasonable trier of fact could find an objective, reasonable expectation of coverage on the part of Winters.

IV.

CONCLUSION

[8] We reverse and remand with instructions to enter judgment in favor of Costco.

REVERSED AND REMANDED.

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APPENDIX B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

DONNA COLE WINTERS,	)	
	)	
	)	
Plaintiff,	)	No. C92-581WD
	)	
v.	)	ORDER ON
	)	MOTIONS FOR
COSTCO WHOLESALE GROUP	)	SUMMARY
BENEFITS PROGRAM, a	)	JUDGMENT
group benefit plan;	)	
and CONCEPT	)	
ADMINISTRATORS, INC., a	)	
California	)	
corporation,		
Defendants.		

I. INTRODUCTION

In an attempt to conceive a child, plaintiff Donna Cole Winters underwent a gamete intrafallopian transfer ("GIFT") procedure in December 1990. Plaintiff's employee health benefits plan denied her

claim for reimbursement of GIFT-related expenses on the ground that the plan excludes " [c]harges in connection with in-vitro fertilization." Plaintiff now sues the benefits plan and its claims administrator under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq. ("ERISA"), for medical expenses, prejudgment interest, and attorney fees and costs.

Both sides have moved for summary judgment. Defendants seek summary judgment of dismissal. Plaintiff seeks summary judgment under ERISA determining that she is entitled to reimbursement for the expenses of the GIFT procedure performed on December 17, 1990. All materials filed in support of or opposition to

the motions have been fully considered. No party has requested oral argument and none is necessary.

II. UNDISPUTED FACTS

Plaintiff is a participant in the Costco Wholesale Group Benefits Program ("Costco"), a self-insured employee benefits plan established under ERISA, 29 U.S.C. § 1002(1). Between 1983 and August 1990 plaintiff underwent several fertility-related treatments, including laprascopic surgery, in vitro fertilization ("IVF"), and at least two prior GIFT procedures.

Under the terms of the benefits plans in effect prior to August 1990 defendants paid some of plaintiff's claims but denied others. in August 1990 a new

benefits plan took effect. Section 6.31 of the plan excludes from coverage "[c]harges in connection with in-vitro fertilization." See Defendants' Ex. 2. There is no mention of GIFT procedures.

On December 17, 1990, plaintiff underwent another GIFT procedure. This one was performed at the University of Washington Hospital. The procedure involves retrieving eggs from the patient's ovaries and placing the eggs, along with sperm, in the patient's fallopian tube. Fertilization takes place in the fallopian tube.

Plaintiff submitted a timely claim for reimbursement of the GIFT-related expenses. The claim was denied by Concept Administrators, Inc., Costco's claims ad-

ministrator, as a "charge[i in connection with in-vitro fertilization." The denial was affirmed by Costco with advice from Ethix Northwest, a consulting firm to health benefits providers.

The record reflects that none of the five persons on Costco's "medical review staff" had a medical degree. In a deposition one reviewer admitted being unfamiliar with the terms "gamete intrafallopian fertilization" or "GIFT." See plaintiff's Ex. A. The input from Ethix Northwest consisted of a letter from a doctor that reads: "I have reviewed the documents provided concerning [Donna Cole Winters]. The procedure is specifically for the treatment of infertility and does involve invitro [sic] fertilization of harvested

oocytes . . . ." Defendants' Ex. 1 (Letter from Dr. Frank Schramm to Lynn Gorlick, Concept Administrators, 4/17/91). It is not known what documents the doctor reviewed or in what specialty of practice he engaged.

Plaintiff brought this action challenging the denial of benefits in King County Superior Court in February 1992. The case was removed to this court in April 1992. The main issue presented by the motions for summary judgment is whether the plan administrator violated ERISA in classifying the GIFT procedure as in vitro fertilization in denying coverage.

III. SUMMARY JUDGMENT STANDARD

Summary judgment under Fed. R. Civ. P. 56 may be granted if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. An issue of material fact is One that affects the outcome of the case and requires a trial to resolve differing versions of the truth. Admiralty Fund v. Hugh Johnson & Co., 677 F.2d 1301, 1305-06 (9th Cir. 1982). In deciding the motion the court views the evidence in the light most favorable to the non-moving party, and draws all reasonable inferences in that party's favor. Poller v. Columbia Broadcasting System. Inc., 368 U.S. 464, 473 (1962); T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Ass'n, 809 F.2d 626, 630-31 (9th Cir. 1987).

However, the non-moving party must respond to an adequately supported motion by showing that a genuine issue of material fact exists; if the response falls short of that, summary judgment should be granted. red. R. Civ. P. S6(e); T.W. Elec. Serv., Inc., 809 F.2d at 630-31.

IV. STANDARD OF REVIEW

The 1990 health plan states that "[t] Plan Administrator had [sic] the absolute discretion and authority to construe disputed or seemingly inconsistent provisions of the Plan and to make all decisions regarding eligibility and/or entitlement to coverage or benefits." 1990 Plan § 14.9.

The parties agree that where a plan gives the administrator discretionary

authority to determine eligibility for benefits, the administrator's decision is ordinarily reviewed for abuse of discretion. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989). Plaintiff argues that the plan administrator here is a fiduciary with a conflict of interest, and that the decision is therefore "suspect and entitled to little if any deference." See plaintiff's Memorandum in Opposition at 2-7 (citing Brown v. Blue Cross & Blue Shield of Alabama, 898 F.2d 1556 (11th Cir. 1990, cert. denied, 498 U.S. 1040 (1991)). Defendants deny any conflict of interest and take issue with the standard of review proposed by plaintiff.

The Ninth Circuit has not expressly adopted the standard of review urged by plaintiff. It is unnecessary to decide whether to apply that standard, since plaintiff would prevail even under the more deferential abuse of discretion standard.

V. DISCUSSION

An ERISA plan administrator abuses its discretion if it renders a decision that conflicts with the "plain and ordinary" meaning of a plan term. See Elev. v. Boeing Co., 949 F.2d 276, 279 (9th Cir. 1991); Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 536 (9th Cir. 1990). The parties disagree as to the plain and ordinary meaning of the term "in vitro fertilization." The IVF exclu-

sion is the only basis argued by defendants for not affording coverage herein.

Webster's College Dictionary defines "in vitro fertilization" as a "technique by which an ovum is fertilized with sperm in a laboratory dish and subsequently implanted in a uterus for gestation." Random House - Websters College Dictionary (1991)" Accord Stedman's Medical Dictionary (25th Ed. 1990).

GIFT, in contrast, involves fertilization of the eggs within the fallopian tube. Thus IVF and gift are distinct treatments for infertility. For comparative descriptions of the two procedures See Jean M. Eggen, The "Orwellian Nightmare" Reconsidered: A proposed Regulatory Framework for the Advanced Reproductive

Technologies, 25 Ga. L, Rev. 625, 63S (1994 (citing American Fertility Society, In vitro Fertilization-Embryo Transfer in the United States: 1988 Results from the IVF-ET Registry, 53 Fertility & Sterility 13, 14 (1990)i; Susan Goldberg, Of Gametes and Guardians: The Impropriety Of Appointing Guardians Ad Litem for Fetuses and Embryos, 66 Wash. L. Rev. 503, 513 (1991) (citing United States Congress,. Office of Technological Assessment, Infertility: Medical and Social Choices 117-35 (1988)); plaintiff's Ex. D at 17-IS, 42- 43.

Defendants assert, however, that the plain and ordinary meaning of "in vitro fertilization" is something other than the "technical interpretation of the

term[]" provided by the dictionary and medical texts. Defendants' Reply at 7. They contend that IVF "has an acceptable medical meaning that encompasses an array of procedures dealing with the problem of infertility . . . including GIFT." Id. at 7-8.

In support of this assertion defendants point to six of plaintiff's medical charts prepared by hospital personnel in connection with her gift procedure. Those charts contain notations such as "Proposed Operation: IVF"; "in vitro fertilization patient"; "IVF patient"; "IVF Program". See Defendants' Ex. 3.

Defendants also cite Dr. Donald Moore's statement that "you can kind of loosely use" the term IVF to include pro-

cedures such as GIFT. See Defendants' Reply Ex. 2 at 30. Dr. Moore is a staff member of the University of Washington School of Medicine and is certified in obstetrics, gynecology and reproductive endocrinology. But Dr. Moore's statement and the "IVF" notations on the hospital charts are not dispositive. As Dr. Moore explains:

> [R]eally it's ART that refers to all the procedures we do. IVF is just one of the procedures, and it's loosely used [at the University of Washington Hospital] because that's primarily what we do. We do IVF . . .[T]he Program started using IVF in 1984. GIFT came along about two years later . . . [W]e don't do very many GIFT procedures. So we still sort think of our program as we did in the beginning as an IVF program.

Plaintiff's Ex. D at 30-33. The "loose" usage of the two terms at a single hospital fails to show an "acceptable medical meaning" that treats them as interchangeable when, if used correctly, they are not.

Defendants also offer the deposition of Dr. Bruce Amundson of Ethix Northwest, who consulted with Costco about plaintiff's claim. Dr. Amundson, who does not specialize in obstetrics, gynecology, or reproductive endocrinology, differentiates between a looser and stricter usage of the term IVF. He states that:

> [i]n-vitro fertilization . . . has tended to describe a number of procedures used in a general sense. In a more specific . . . physiologic sense, it describes " " " fertilization . . . out of the body, and the reintro-

> duction of the fertilized ovum into the human.

Defendants' Reply Ex. 1 at 12. Dr. Amundson also states: "[M]y interpretation would be that . . . the in-vitro fertilization term has tended to cover . . . artificial technologies such as the GIFT procedure." Id. at 24.

Under the "plain and ordinary meaning" of IVF as provided by the dictionary and medical text sources, the administrator's decision cannot stand because it conflicts with that meaning and therefore constitutes an abuse of discretion. GIFT, unlike IVF, involves in vivo -- specifically, intrafallopian -- fertilization of the egg. If the "plain and ordinary meanings" of IVF and GIFT set out

above were not used, then "IVF" -- the term used in the plan -- would have to be deemed ambiguous. Defendants' expert, Dr. Amundson, has testified:

> Q: Do you think the Costco policy is ambiguous with respect to the GIFT procedure?
> A: In retrospect it may be ambiguous, and I say that because of the continuing lack of clarity . . . (in the way] that term has been used . . . .
>
> * * *
>
> Q: Do you think a patient would be confused, Doctor, if they read [the University of Washington Medical Center's informational pamphlet entitled "Assisted Reproductive Technologies"], then looked at their (Costco] policy which said in vitro fertilization was excluded; would that create confusion?
> A: Yes, I think it could.
> Q: Would a patient, perhaps justifiably, think the GIFT procedure would be covered?
> A: They might.

Plaintiff's Ex. C at 21, 27. See also Dr. Amundson's comment that "my interpretation would be that . . . the in-vitro fertilization term has tended to cover . . . artificial technologies such as the GIFT procedure." Defendants' Reply Ex. 1 at 24 (emphasis added).

The Ninth Circuit has adopted the rule of contra proferentem for the construction of ambiguous terms in ERISA health plans. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534 (9th Cir. 1990). Under that rule, ambiguous terms in an insurance contract are to be construed in the favor of the insured. In Kunin, an ERISA plan participant incurred over $50,000 in medical bills for the treatment of autism. The insurer and plan ad-

ministrator decided that autism was a "mental illness" and invoked the plan's $10,000 cap on payment of costs for treating "mental illness." The district court looked to "the plain and ordinary meaning that a lay person would ordinarily attach" to the term "mental illness." Kunin v. Benefit Trust Life Ins. Co., 696 F. Supp. 1342, 1345 (C.D. Cal. 19S8). The court concluded that the plan administrator's "inclusion of autism within the limitation clause covering 'mental illness' was not a reasonable interpretation of the . . . plan." Id. at 1347.

The court of appeals affirmed the district court's analysis. In an alternative holding, the court found in favor of the plan participant by applying the rule

of contra proferentem. It examined whether "the term 'mental illness' is so clear and well fixed that an ordinary reader of the policy would recognize that autism must be included." Id. at 541. The court found that the term "had no precise or generally accepted definition." Id. It further observed that the policy "contain[ed] no definition or explanation of the term 'mental illness,' and offer[ed] no illustration of the conditions that are included or excluded." Id. "Under these circumstances/ we conclude that term 'mental illness' is ambiguous. Id.

Applying contra proferentem, the court then construed the ambiguity in fa-

vor of the insured, noted that all fifty states apply that rule, and stated:

> Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

910 F.2d at 540. Cf. Eley v. Boeing Co., 945 F.2d 276, 280 (9th Cir. 1991) (refusing to apply the rule of contra

proferentem to self-insured ERISA plans that "result from arms-length bargaining by parties of equal power, as in the case of collective bargaining agreements").

There is no evidence that the Costco plan was the result of arms-length bargaining by parties of equal power. The plan makes no attempt to define or explain the term "in vitro fertilization" and offers no illustration of the treatments that are included or excluded. "Insurance contracts generally spell out in inordinate detail the meaning of terms that lack a fixed meaning." Kunin, 910 F.2d at 541. Had the plan meant to exclude GIFT it could have expressed that intent clearly. Alternatively, it could have replaced the term "IVF" with

"assisted reproductive technologies" ("ART"), which would have encompassed IVF, GIFT, and related procedures. For uses of the term "ART" See Plaintiff's Ex. C at 11, E, F. See also Eggen, supra at 629 n.6.

It follows that plaintiff's motion for summary judgment must be granted, and defendants' motion for summary judgment under ERISA must be denied.

VI. STATE LAW CLAIMS

The amended complaint asserts two state claims, one for breach of fiduciary duties and one for breach of contract. Plaintiff has withdrawn the former claim. See Defendants' Ex. 1, Plaintiff's Response to Defendants' First Set of Interrogatories and Requests for Production at

No. 9. The common law breach of fiduciary duties claim is therefore dismissed.

The contract claim, though not raised in plaintiff's motion for summary judgment, has not been withdrawn. This clam is preempted by ERISA because it "relates to" an employee benefit plan governed by that statute and is "based upon common law of general application that is not a law regulating insurance." See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 62 (1987); Pilot Life Is. Co. v. Dedeaux, 481 U.S. 41, 48 (1987). Accordingly, the contract claim is dismissed as preempted.

VII. CONCLUSION

For the reasons stated, plaintiff's motion for summary judgment under ERISA

determining that she is entitled to reimbursement of the expenses incurred in her December 17, 1990, GIFT procedure is granted, and defendants' summary judgment motion under ERISA is denied. Defendant's motion for summary judgment dismissing the state claims as abandoned or preempted is granted. Plaintiff's motion for attorney fees, costs, and prejudgment interest will be due on July 8, 1993, and will be briefed and noted on the timetable established by the local rules of this court.

The clerk is directed to send copies of this order to all counsel of record.

Dated: June 24, 1993.

William L. Dwyer
United States District Judge

5YDK4

APPENDIX C

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DONNA COLE WINTERS,	)	
	)	
Plaintiff-Appellee,	)	No. 93-35851
	)	
v.	)	D.C. No. CV-92-00581-WLD
COSTCO WHOLESALE CORPORATION, a Washington corporation; CONCEPT ADMINISTRATORS, INC., a California corporation,	)	ORDER
Defendants-Appellants.	)	

Before: LAY,* TROTT and T.G. NELSON, Circuit Judges.

Judges Lay, Trott and T.G. Nelson vote to deny the petition for rehearing.

Judges Trott and T.G. Nelson vote to

---

* Honorable Donald P. Lay, Senior United States Circuit Judge for the Eighth Circuit, sitting by designation.

reject the suggestion for rehearing en banc, and Judge Lay so recommends.

The full court was advised of the suggestion for rehearing en banc and no active judge requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

5YDK3

(3)

Supreme Court, U.S.
FILED
AUG 17 1995
OFFICE OF THE CLERK

No. 95-116

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

DONNA WINTERS, an individual person,

Petitioner,

v.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM and CONCEPT ADMINISTRATORS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Must the doctrine of contra proferentem be applied to overturn a plan administrator's interpretation of an employee benefit plan when the plan administrator did not abuse its discretion in making such interpretation?

2. Given Petitioner's evident disregard to whether the GIFT procedure is a Covered Charge under the plan and the Ninth Circuit Court of Appeals' holding that the Plan Administrator did not abuse its discretion, will she be entitled to benefits even if she prevails on the contra proferentem issue she has raised in this appeal?

PARTIES

Petitioner is Donna Cole Winters, an individual. Respondents are Costco Wholesale Group Benefits Program (the "Plan"), a group benefit plan, and Concept Administrators, Inc. ("CAI"), which merged into Core Source, Inc., a Delaware corporation, in December 1993. Concept Source, Inc., is Costco's third-party claims administrator.

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Winters v. Costco Wholesale Group Benefits Program & Concept Adm'rs, Inc., No. C92-581WD (June 24, 1993). 1

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No. 95-116

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

DONNA WINTERS, an individual person,

Petitioner,

v.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM and CONCEPT ADMINISTRATORS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

OPINIONS BELOW

In an unpublished decision, the United States District Court for the Western District of Washington granted summary judgment for Ms. Winters. *Winters v. Costco Wholesale Group Benefits Program & Concept Adm'rs. Inc.*, No. C92-581WD (June 24, 1993). Costco and Con-

cept appealed the decision to the United States Court of Appeals for the Ninth Circuit. The Ninth Circuit unanimously reversed the district court's ruling and remanded the case with instructions to enter judgment in favor of Costco. *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995), *petition for cert. filed* (July 18, 1995). The Ninth Circuit denied Winters' request for rehearing, and her request for a rehearing *en banc* was rejected on April 19, 1995.

STATEMENT OF JURISDICTION

The Court has jurisdiction over this matter under 28 U.S.C. §1254(1).

STATUTES INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001 *et seq.*

STATEMENT OF THE CASE

This is an undistinguished dispute between Winters and the Costco Wholesale Group Benefits Plan. The dispute centers on whether the cost of Petitioner's elective medical infertility treatment should be borne by the Plan. The administration of the Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA").

Before undergoing the treatment in question, Winters inquired whether the Plan would reimburse her for her costs related to a gamete intrafallopian transfer ("GIFT") procedure. The administrator of the Plan, the Costco Wholesale Group Benefits Plan Administration Committee (the "Plan Administrator"), informed Winters

the treatment would not be covered. Winters nevertheless underwent the treatment and then submitted a benefits claim to the Plan Administrator.

The Plan Administrator denied Winters' claim for benefits because (1) the elective treatment was not "medically necessary" as defined in the Plan and (2) the treatment was expressly excluded by the Plan. The Administrator's decision was predicated on a common Plan provision which granted the Plan Administrator broad discretionary authority to interpret and construe the benefits provisions of the Plan.

Winters subsequently brought this action against the Plan to recover benefits, contending that a court should apply certain insurance contract principles to the interpretation of self-funded employee benefit plans governed by ERISA. Winters also joined CAI, a third-party administrator of the Plan which acts as an agent of the Plan Administrator in processing Plan benefit claims.

Winters originally brought suit in February 1992, in the Superior Court of King County, Washington, alleging the denial of benefits was wrongful and a breach of contract under state law. On April 6, 1992, Respondents removed the case to the United States District Court for the Western District of Washington. After discovery, both Respondents and Winters moved for summary judgment. Respondents moved for dismissal of all claims. Winters narrowed her claim to reimbursement for expenses incurred for a GIFT medical procedure that was performed on December 17, 1990. The District Court awarded summary judgment in favor of Winters, ruling she was entitled to benefits under ERISA, but that her state law breach of contract action for the same benefits was preempted by ERISA.

The Ninth Circuit Court of Appeals reversed Winters' summary judgment. It held that a court should apply a stringent version of the abuse of discretion standard in reviewing an administrator's decision when the administrator has been granted discretionary authority under the plan. Under this standard, the court then found that the Plan Administrator had not abused its discretion in denying Winters' claim. The court also ruled that the insurance contract construction doctrine of contra proferentem does not apply to a case in which an administrator has been granted discretionary authority. In addition, for purposes of determining whether Winters could be entitled to relief under the decision of *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994), the Court of Appeals found ". . . there is no evidence in the record upon which a reasonable trier of fact could find an objective, reasonable expectation of coverage on the part of Winters." *Winters*, 49 F.3d at 555.

Winters then filed her petition to this Court.

SUMMARY OF THE ARGUMENT

This fact-specific case provides no issue appropriate for the Court's exercise of its discretionary jurisdiction. The GIFT procedures, which Petitioner voluntarily elected to undergo, were not reasonably necessary for the diagnosis and treatment of any illness or injury as was required before benefits could be provided under the Plan. The procedures were generally excluded from Plan coverage and specifically excluded by the Plan's denial of coverage for invitro (literally in glass) fertilization.

In addition, to recover benefits Petitioner must show the GIFT procedure was a Covered Charge and the Plan Administrator abused its discretion in determining bene-

fit eligibility *and* the Ninth Circuit was wrong in refusing to apply the rule of contra proferentem to the facts of this case. Despite this, Petitioner only challenges the Appeals Court's refusal to apply the contra proferentem rule, leaving unchallenged the court's independent holding that the Plan Administrator did not abuse its discretion in denying benefits to Petitioner.

Finally, despite Petitioner's contrary agrument, there is no significant division among the Circuits on relevant issues which merits this Court's resolution.

REASONS FOR DENYING THE WRIT

I.

BACKGROUND: THE ABUSE OF DISCRETION ERISA STANDARD OF REVIEW WAS NOT VIOLATED BY THE DENIAL OF BENEFITS TO WINTERS, WHO IGNORED ADVICE THAT THE GIFT PROCEDURES WERE NOT COVERED BY THE PLAN.

This case turns on what standard of review should be used when examining an ERISA plan fiduciary's interpretation of a medical benefit plan. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court established the abuse of discretion standard of review under ERISA. This petition is now before this Court because Petitioner believes that the insurance policy construction doctrine rule of contra proferentem should apply in all ERISA cases.

The Plan Administrator is required to administer the Plan within the meaning of section 3(16)(A) of ERISA, 29 U.S.C. §1002(16)(A). Under section 404 of ERISA, 29 U.S.C. §1104, the Plan Administrator is obligated to administer the Plan in the best interest of all Plan participants and beneficiaries.

Benefits under the Plan are self-insured by Costco. CAI is responsible for processing claims for Plan benefits. CAI is not a fiduciary. Its decisions are subject to review by the Plan Administrator.

As required by section 503 of ERISA, 29 U.S.C. §1133, Article XIV of the Plan contains procedures by which Winters' claim for benefits was reviewed by the Plan Administrator. Section 14.9 of the Plan gives the Plan Administrator broad authority to interpret the Plan and make benefits determinations:

> [T]he Plan Administrator shall have full discretion and authority to interpret or construe all provisions of the Plan in making its determinations. . . . The Plan Administrator had [sic] the absolute discretion and authority to construe disputed or seemingly [sic] inconsistent provisions of the Plan and to make all decisions regarding eligibility and/or entitlement to coverage or benefits.

It is undisputed that Winters has been employed by Costco and is a participant in the Plan. She underwent various treatments for infertility from 1983 through 1990. The Plan paid for some of these procedures but not for others. On December 17, 1990, after she was twice notified that invitro fertilization procedures were excluded from Plan coverage, Winters underwent the GIFT procedure. This procedure involves retrieving eggs from the patient's ovaries and placing the eggs, along with sperm, in the patient's fallopian tube.

Winters then filed a claim for Plan benefits in connection with the 1990 GIFT procedure despite the fact that Section 6.19 of the Plan specifically excluded "in vitro fertilization." CAI denied Winters' claim on the ground that GIFT is a type of in vitro fertilization.

Pursuant to the broad grant of discretionary authority to interpret the language of the Plan, the Plan Administrator then determined that GIFT was not a "Covered Charge" under the Plan because it was not "medically necessary" and that GIFT was within the Plan's express exclusion of in vitro fertilization.

The district court ruled that the Plan Administrator abused its discretion in denying benefits to Winters. It reasoned that the term "in vitro fertilization" was not the same as GIFT.[1] Thus, it found that the Plan Administrator abused its discretion in relying on the in vitro exclusion to deny benefits. In an alternate ruling, based on *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990), the district judge applied the doctrine of contra proferentem and construed the in vitro exclusion narrowly and against the drafter, Costco.

Respondents appealed both rulings to the Ninth Circuit Court of Appeals. As to the first ruling, the Ninth Circuit ruled that the district judge misapplied the abuse of discretion standard of review enunciated in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and that the Plan Administrator had not abused its discretion. *Winters*, 49 F.3d at 553-54. The court separately ruled that the district judge had misinterpreted *Kunin*, and that the doctrine of contra proferentem does not apply

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[1] The district court defined "in vitro fertilization" as fertilization of eggs outside of the body in a laboratory dish and placement of fertilized eggs in the uterus of the patient. GIFT, on the other hand, involves retrieving eggs from the patient's ovaries and placing the eggs, along with sperm, in the patient's fallopian tube. The apparent distinction was the location in the body in which the egg and sperm are placed.

to self-insured ERISA covered plans that grant broad discretionary authority to the plan administrator to interpret the terms of the plan. *Id.* at 554.

II.

ANY RULING BY THIS COURT WILL NOT RESULT IN RELIEF FOR PETITIONER BECAUSE PETITIONER DOES NOT SEEK REVIEW OF THE RULING THAT THE PLAN ADMINISTRATOR DID NOT ABUSE ITS DISCRETION.

The Ninth Circuit made two independent rulings in this case, both in favor of Respondents: first, it applied a heightened standard of review to offset the Plan Administrator's conflict of interest, and nonetheless held the Plan Administrator did not abuse its discretion in denying benefits for Petitioner's GIFT procedure, *Winters*, 49 F.3d at 553-54, and, second, it held that the doctrine of contra proferentem does not apply to self-funded ERISA plans that grant discretionary authority to a Plan Administrator to interpret the plan. *Id.* Petitioner challenges *only* the second holding.[2] As more fully explained below, she does not challenge the ruling that the Plan Administrator did not abuse its discretion in denying benefits. Therefore, even if this Court were to rule in favor of Petitioner on the issue of contra preferentem, the Ninth Circuit's holding that the Plan Administrator did not

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[2] Petitioner does claim that "an administrator abuses its discretion by failing to interpret [Plan] ambiguities in favor of the insured." Petitioner's Brief at 11. However, as the opinion below indicates, the finding that the Plan Administrator did not abuse its discretion and the inapplicability of contra proferentem to the facts of this case are independent and unrelated concepts. It is not an abuse of discretion for a plan administrator to not apply contra proferentem. Contra proferentem is a tool adopted by the *courts* for application by the *courts.*

abuse its discretion is unchallenged and Winters would still not be entitled to recover benefits.[3]

The abuse of discretion standard applied by the Ninth Circuit in this case was based on this Court's seminal decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). *Bruch* requires a court to make a de novo determination of whether a claimant is entitled to benefits under an ERISA plan, unless the plan gives the administrator discretionary authority to interpret the plan. If such discretion is granted, a court is to give deference to the decision of the plan administrator and only overturn a denial of benefits if the administrator abused its discretion.[4] *Id.* at 11.

Since the Plan granted discretionary authority to the Plan Administrator, the Ninth Circuit analyzed its decision under the abuse of discretion standard as follows:

> In evaluating Winters' claim the Plan Administrator relied on a statement of a consulting physician that GIFT consists of surgical removal of eggs from the ovaries of the patient combining the eggs with sperm outside of the patient's body, or "in vitro," and

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[3] In order to recover benefits, Petitioner would also have to establish that application of contra proferentem to save GIFT from the reach of the invitro exclusion results in GIFT being a "Covered Charge." The Plan does not include any reproductive procedures in its covered charges provisions. *See Winters*, 49 F.3d at 553.

[4] Some courts have used the term "arbitrary and capricious" to describe this deferential standard of review. The Ninth Circuit Court of Appeals generally uses the term "abuse of discretion," but has noted that there is no practical distinction between the two terms. *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 n.2 (9th Cir. 1993), *amended* 94 C.D.O.S. 1577, *reprinted as amended*, 1993 U.S. App. LEXIS 36315 (9th Cir. 1994).

> then placement of the same into the patient's fallopian tube. The Plan Administrator also reviewed Winters' medical records from the University of Washington Medical Center which characterized her procedure as "in vitro." . . . Winters has vigorously maintained and the district court agreed that GIFT and in vitro fertilization are distinguishable. However, this does not necessarily demonstrate that the interpretion given to "in vitro fertilization" by Costco clearly conflicts with the plain language of the Plan. . . . *Based on the evidence in the administrative record*, Costco's interpretation was not unreasonable.

Winters, 49 F.3d at 553-54 (emphasis added; citations omitted).

The district court concluded from the record presented by the parties on cross motions for summary judgment that the Plan Administrator had not abused its discretion. It reasoned:

> "Our inquiry is not into whose interpretation of the plan documents is most persuasive, but whether the plan administrator's interpretation is unreasonable." . . . Based on the evidence in the administrative record, Costco's interpretation was not unreasonable. The Plan made clear that the Plan Administrator had the final determination of benefit decisions. The district court erred in second-guessing the exercise of discretion, because there was no abuse of that discretion. . . . [E]ven if Costco has an interest in broadly construing the in vitro exclusion, there are no indications that the conflict had an impact on the decision to deny benefits.

Id. at 554 (citations omitted).

Petitioner does not demonstrate that the Ninth Circuit erred in its assessment under the abuse of discretion

standard, nor does she otherwise challenge that court's finding that there was no abuse of discretion. Petitioner's motion for summary judgment was based on the record submitted to the district judge. It vigorously contended that GIFT and in vitro fertilization are different procedures. As to the abuse of discretion ruling, Petitioner only says that the Ninth Circuit "did not consider whether Costco's investigation to determine the meaning of 'in vitro' was arbitrary and capricious. . . ." Petitioner's Brief at 52-53. This is a mischaracterization of the Ninth Circuit's opinion. Since the Ninth Circuit ruled that the Plan Administrator's interpretation of "in vitro" was not an abuse of discretion separate and apart from any need to apply the rule of contra proferentem, Petitioner's stance can only be interpreted as an acquiescence in that ruling.

Petitioner originally had a personal stake in the outcome of this suit. However, Petitioner has chosen to limit her challenge to the Ninth Circuit's ruling on the issue of contra proferentem. Since the other independent ground for denying her claims stands unchallenged, Petitioner has eliminated her personal stake in the outcome of this suit. *See Rosetti v. Shalala*, 12 F.3d 1216, 1224 (3d Cir. 1993) (developments occurring during adjudication can eliminate a plaintiff's personal stake and render a case moot).

A similar analysis was applied in *Ashcroft v. Mattis*, 431 U.S. 171 (1977). In that case, a lawsuit was brought under 42 U.S.C. §1983 by the father of an individual who had been killed by police while attempting to escape arrest. The father sought both damages and a declaratory judgment that the state statutes authorizing the police action were unconstitutional. The district court denied relief on both actions after finding that the defendants

had acted in good faith. The plaintiff appealed only the ruling on the declaratory judgment, not the damages claim, and on remand amended his complaint to seek only a declaratory judgment that the state law was unconstitutional. The Eighth Circuit Court of Appeals agreed that the statute was unconstitutional. This Court ruled that the case did not represent a live case or controversy after the plaintiff dropped the damages claim under 1983. *Ashcroft,* 431 U.S. at 172. The finding that the police officers were not liable to the plaintiff was final and could not be raised again. The Court said, "here, the District Court was asked to answer the hypothetical question whether the defendants would have been liable apart from their defense of good faith. No 'present right' of appellee was at stake." *Id.; cf. Haislah v. Walton*, 748 F.2d 359 (6th Cir. 1984).

Petitioner asks this Court to answer the hypothetical question of whether Respondents could have been liable under a contra proferentem analysis apart from the defense that the Plan Administrator did not abuse its discretion when it denied Petitioner's claim for benefits. Obviously, Petitioner and others may file future claims for benefits under the Plan. Presumably, Petitioner prefers that the doctrine of contra proferentem apply in such *future* cases. However, as stated in *Ashcroft*, this is insufficient to show that there is a present, live controversy between the parties. *Ashcroft*, 431 U.S. at 172 n.2. A ruling on the applicability of contra proferentem to ERISA cases may be of academic interest, but it will not decide this case in Petitioner's favor.

III.

PETITIONER MUST SHOW THAT GIFT WAS A "COVERED CHARGE" TO PERFECT HER CLAIM FOR BENEFITS UNDER THE PLAN.

The Plan document states in Section 5.1 that benefits are only available if a Plan participant incurs a "Covered Charge." Covered Charges are generally identified in Article V of the Plan as expenses that are medically necessary for the treatment of an illness or an injury. Article V of the Plan does not identify in vitro fertilization, GIFT or any other reproductive technology as a covered charge.

In addition, the Plan identifies numerous medical procedures that are excluded from coverage, whether or not they might be Covered Charges. Section 4.1 of the Plan states that benefits are only paid if a medical expense is both a Covered Charge and is not excluded under the Plan.

Petitioner's claim was denied on the dual grounds that the GIFT procedure is a type of in vitro fertilization expressly excluded by the Plan *and* the GIFT procedure was not within the Plan's definition of Covered Charge. Petitioner's argument that GIFT is not the same as in vitro fertilization is only partially useful to her. Her argument does not address the fact that the GIFT procedure is not a Covered Charge.[5]

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[5] The Ninth Circuit found that it did not need to rule on whether the GIFT procedure was a Covered Charge because it found Petitioner's contra proferentem theory did not get her over the hurdle of the Plan's invitro exclusion. *Winters*, 49 F.3d at 554. The Court also noted that the Plan Administrator had informed Petitioner before she underwent the GIFT procedure that she would not receive benefits because GIFT is not medically necessary for treatment of an accidental injury or illness, as required under the Plan's covered charge provision. *Id.* at 555.

IV.

THE CIRCUIT COURTS OF APPEAL ARE NOT SUBSTANTIALLY DIVIDED ON THE DOCTRINE OF CONTRA PROFERENTEM.

In view of the above, and to the extent it remains relevant to this case, Petitioner attempts to characterize the current state of the doctrine of contra proferentem as a labyrinth that creates widespread confusion. This is not accurate. None of the authorities cited by Petitioner would have led to a different result had they been applied by the Ninth Circuit in this case. With only a few exceptions, the decisions cited by Petitioner involved a de novo review and are inapposite to this case. Most cases involving a deferential standard of review have not applied contra proferentem to evaluate the decision of a plan administrator. As distinguished *infra*, a few courts have used contra proferentem as a tool for an unrelated, limited purpose that does not apply here.

A. Courts Are Not Divided on Applying *Firestone v. Bruch* to Determine the Standard of Review in a Case Involving a Claim for Benefits.

Petitioner expresses concern that courts have been confused about how to adjudicate cases involving different types of ERISA benefit plans. She reasons that the different standards may apply if a plan is fully insured, if it is self-funded, if it grants discretionary authority to the administrator or if the administrator has a conflict of interest. She also contends the courts are confused about when to apply the doctrine of contra proferentem to an ERISA case. *See* Petitioner's Brief at 7-12. This elaborate analysis creates artificial categories of distinc-

tion and is misleading.[6] In reality, cases decided since *Firestone v. Bruch* routinely apply either a de novo review or abuse of discretion standard of review. A reading of the few post-*Bruch* cases that have discussed the contra proferentem doctrine demonstrates that the key issue in those cases has been the application of the de novo review or abuse of discretion standards. The contra proferentem doctrine is of less importance.

The reason that contra proferentem has not been a main feature in the decisional law is that *Firestone v. Bruch* based its holdings on concepts of trust law, not insurance or contract law. *Bruch*, 489 U.S. at 110-11. The Court noted that ERISA codified certain trust law principles and made those principles applicable to a wide range of fiduciaries. *Id.* at 110. A fiduciary must "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries; and . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA]." ERISA §404(a), 29 U.S.C. §1104(a). Moreover, a plan participant who is denied benefits is entitled to a "full and fair review" of the claim by the appropriate named fiduciary of the plan. ERISA §503, 29 U.S.C. §1133. In other words, the relationship among a plan sponsor, the plan administrator and the plan participants is not arm's length. Accordingly, the rule of contra proferentem, which was established by state courts in the context of arm's length

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[6]Petitioner's elaboration of widely divergent applications of contra proferentem should be suspect by its own weight under the rule of *Ockham's Razor*, i.e., that the simplest of two or more competing theories is preferable.

transactions between parties of unequal bargaining power, has not been the centerpiece of ERISA litigation after *Bruch*.

Since all ERISA plans are subject to ERISA's standards, the *Bruch* Court stated that the standards of fiduciary review apply

> . . . regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion."

Bruch, 489 U.S. at 115 (quoting Restatement (Second) of Trusts). Thus, the *Bruch* decision itself belies the distinctions Petitioner has suggested in creating the appearance of confusion in the circuits.

B. The Circuits Are Essentially Consistent in Their Application of the Doctrine of Contra Proferentem.

Petitioner asserts that "[t]he circuits are irreconcilably split regarding whether and to what extent contra proferentem applies under ERISA." Petitioner's Brief at 11-12. This is inaccurate. On closer examination, her discussion creates the appearance of an "irreconcilable" split by slotting cases into artificial categories. As discussed above, the primary focus of the courts since *Firestone v. Bruch* has been to determine if the *de novo* or abuse of discretion standard applies to the review of a particular fiduciary or plan administrator decision. Viewed in this light, the distinctions between the circuits are not difficult to reconcile.

The contra proferentem authorities cited by Petitioner in support of her argument for de novo review are completely inapposite to this case. In those decisions, the court was obligated to decide the interpretation of the plan itself. Indeed, the primary authority cited in support of Petitioner's claim, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990), involved a de novo review of a claim for benefits.

Moreover, as noted by the Ninth Circuit, *Kunin* only stands for the proposition that contra proferentem should be applied to those cases in which the instrument does not indicate how ambiguous terms will be interpreted. *Winters*, 49 F.3d at 554 (citing *Kunin*, 910 F.2d at 539).

> In contrast [to *Kunin*] the Plan here states that the Plan Administrator has "the absolute discretion and authority to construe disputed or seemingly inconsistent provisions of the Plan and to make all decisions regarding eligibility and/or entitlement to coverage or benefits." The Plan thus states how Plan terms are to be interpreted, and the general rule of contra proferentem does not apply.

Id. In other words, the Ninth Circuit has not limited or, as Petitioner suggests, misread *Kunin*. It recognizes that *Kunin* can only apply as a precedent when a de novo review would otherwise be appropriate. Read in this light, the Ninth Circuit's decision in *Winters* is not out of harmony with those courts that have adopted *Kunin*.

Most of the other authorities cited by Petitioner involve a de novo review.

Nearly all of the authorities cited by Petitioner relied on the Ninth Circuit's ruling in *Kunin*. Petitioner claims

that "[m]ost circuits generally follow *Kunin*, and thus agree that contra proferentem applies to ERISA insurance policies. . . ." Petitioner's Brief at 11. However, as noted above, the Ninth Circuit has explained that, under its decision in *Kunin*, contra proferentem should not be applied to interpret the term "in vitro fertilization" in this case because the Plan plainly grants discretionary authority to the Plan Administrator. *Winters*, 49 F.3d at 554.[7]

Petitioner asserts that the courts in *Hanson v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991), and *Springs Valley Bank & Trust Co. v. Carpenter*, 885 F. Supp. 1131 (S.D. Ind. 1992), applied contra proferentem to interpret a plan in an abuse of discretion review. Petitioner's Brief at 14. Petitioner mischaracterizes these cases. There the issue was how to resolve conflicts between plan documents and summary plan descriptions. The courts applied contra proferentem for the limited purpose of determining the make-up of the operative plan document. The court in *Springs Valley Bank & Trust* carefully explained that the doctrine could not be used to interpret ambiguous terms in the plan in a deferential review. Utilizing contra proferentem to interpret ambiguous or inconsistent terms "would violate the limits of judicial review because the plan [sic] has the discre-

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[7] The Eighth Circuit has held that contra proferentem is inconsistent with ERISA, even in a de novo review. *See, e.g., Brewer v. Lincoln Nat'l Ins. Co.*, 921 F.2d 150 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991); *Maxa v. John Alden Life Ins. Co.*, 972 F.2d 980 (8th Cir. 1992), *cert. denied*, 113 S.Ct. 1048 (U.S. 1993); *Finley v. Special Agents Mut. Benefits Ass'n. Inc.*, 957 F.2d 617 (8th Cir. 1992). This alternate approach to a de novo case is inapplicable to the abuse of discretion standard applied by the Ninth Circuit in this case.

tion to interpret ambiguous or conflicting terms and courts may only overturn those interpretations if unreasonable." *Springs Valley Bank & Trust,* 885 F. Supp. at 1141, n.15.

The decision in *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249 (3d Cir. 1993), illustrates another type of limited use that courts make of contra proferentem. There the court had to determine whether the plan language granted sufficient discretion to the administrator to warrant the abuse of discretion standard of review. Citing *Kunin*, the Third Circuit court applied contra proferentem to the plan language and ruled that a de novo review was appropriate. In other words, the court said it would only apply the abuse of discretion standard if the plan unambiguously granted discretionary authority to the administrator. *Id.* at 1256-58.

In another example, Winters claims that *Chauvin v. Texas Instruments, Inc.*, No. 91-2445, 1992 U.S. Dist. LEXIS 13683 (E.D. La. Sept. 5, 1992), stands for the proposition that contra proferentem is inapplicable to an ERISA insurance plan. *See* Petitioners Brief at 57. In reality, the court could not determine whether the plan in question was an ERISA covered plan. Therefore, the court did not decide whether to apply contra proferentem.

Petitioner claims that the Seventh Circuit applied contra proferentem to a case involving discretionary review in the case of *Brewer v. Protexall, Inc.*, 50 F.3d 453 (7th Cir. 1995). Petitioner's Brief at 14. Again, Petitioner has mischaracterized a decision. In *Brewer*, the court expressly stated it did not decide whether the de novo or abuse of discretion standard applied. *Id.* at 456 n.2. It gave the determination of the administrator no deference. *Id.* at 458. The language cited by Peti-

tioner for its claim that the court applied a deferential standard of review was a footnote in which it referenced the decisions in *Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992), and *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990). Both *Phillips* and *Kunin* involved a de novo review, not a deferential one. Thus, *Brewer* is either inapposite, because the standard of review was de novo, or it is an unreliable reading of case law.

Blair v. Metropolitan Life Ins. Co., 974 F.2d 1219, 1222 (10th Cir. 1992), does not identify which standard of review it applied. The court ruled in the plaintiff's favor and said, "We do so without resort to the contra proferentem rule, and without resolving whether that rule should be applied to contracts governed by ERISA."

Generally, courts have not applied the doctrine of contra proferentem in cases involving the abuse of discretion review. *See, e.g., Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995); *Pagan v. NYNEX Pension Plan,* 52 F.3d 438 (2d Cir. 1995); *O'Neil v. Retirement Plan for Salaried Employees of RKO Gen.*, 37 F.3d 55 (2d Cir. 1994); *McDuffey v. Michigan Conference of Teamsters Welfare Fund,* 872 F. Supp. 402 (E.D. Mich. 1994).

A few cases have, on unusual facts not applicable here, applied some type of contra proferentem rule for certain limited purposes, even while purporting to apply a deferential review. For example, *Doe v. Group Hospitalization & Medical Servs.*, 3 F.3d 80 (4th Cir. 1993), involved a fully insured plan in which the insurer denied coverage of a very costly bone marrow transplant. The court

gave the insurer's denial of benefits little deference due to its significant conflict of interest and ruled that the principle of construing contract provisions against the drafter was "helpful as a tool" for making a reasonable decision of an ambiguous provision. *Id.* at 89.

The closest any circuit has come to applying some type of contra rule in an abuse of discretion review is the Eleventh Circuit. However, on close examination, even the decisions indicate that the doctrine is applied in a limited fashion. In *Florence Nightingale Nursing Serv. v. Blue Cross/Blue Shield*, 41 F.3d 1476, 1481 (11th Cir.) (citing *Lee v. Blue Cross/Blue Shield*, 10 F.3d 1547, 1550 (11th Cir. 1994)), *cert. denied*, 115 S.Ct. 2002 (U.S. 1995), the court held that contra proferentem should only be applied in cases in which the administrator has a conflict of interest, and then only if the administrator cannot show that its interpretation of a term was not tainted by self-interest. The court also required that a claimant have a reasonable interpretation of the disputed language in the plan. In short, *Florence Nightingale* does not require application of contra proferentem to resolve all interpretations of ambiguous plan language. It is applied only after the court has determined that there has been an abuse of discretion. In *Winters*, the court found that the Plan Administrator did not abuse its discretion. Petitioner has not challenged this ruling. Thus, the *Florence Nightingale* court's application of contra proferentem to offset a conflict of interest is inapplicable to the present case.

CONCLUSION

The petition before the Court should not be granted. Petitioner will not be entitled to benefits under the Plan even if she prevails on the issue she has presented. The doctrine of contra proferentem does not apply to this case and will not yield benefits to the Petitioner even if applied because the Plan Administrator did not abuse its discretion in denying coverage and the GIFT procedure was not a "Covered Charge."

Respectfully submitted,

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No. 95-116

In The

Supreme Court of the United States

October Term, 1995

DONNA WINTERS, an individual person,

Petitioner,

v.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM AND CONCEPT ADMINISTRATORS, INC.,

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

MOTION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* and BRIEF OF NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE*

MOTION

The National Association of Insurance Commissioners moves for leave to file a Brief *Amicus Curiae* in support of Petitioner, Donna Winters. The Brief *Amicus Curiae* is printed with this motion in accordance with Rule 37 of the *Rules of the Supreme Court*.

ISSUE OF CONSENT

Ms. Yana Koubourlis has consented, on behalf of Petitioner Donna Winters, to our filing a Brief *Amicus*

Curiae. The original form indicating Ms. Winters' consent was submitted to the Clerk of this Court with the filing of this motion and the Brief *Amicus Curiae*. Mr. Hall, on behalf of Costco Wholesale Group Benefits, refused to consent to our filing a Brief *Amicus Curiae*. His refusal was given to NAIC counsel on August 1, 1995 in a telephone conversation.

INTEREST OF MOVANT

The National Association of Insurance Commissioners (NAIC) is a non-profit, unincorporated association whose members consist of the principal insurance regulatory officials of the fifty states, the District of Columbia, territories and insular possessions of the United States. The NAIC seeks permission to file the attached Brief *Amicus Curiae* in furtherance of its objectives to serve the public by assisting the several state insurance regulatory officials in improving state regulation of the business of insurance and promoting fair and equitable treatment of insurance policyholders and claimants.

Issues of federal preemption of state health insurance rules have clogged the courts in recent years. Insureds, regulators, and insurers need the guidance of the Court to resolve preemption issues, to reduce the continuing flow of litigation and to require just application of law. If this Court agrees with the reasoning set forth in the NAIC brief, the Court will grant the Petition for a Writ of Certiorari so that this case may be argued on the merits.

FOCUS OF BRIEFS

The Petition For Writ of Certiorari, submitted on behalf of Donna Winters, details the disagreement among the U.S. Circuit Courts as to whether or not a certain type of insurance policy should be construed in favor of the insured.

Although the Respondent's brief has not yet been filed, it will likely focus on supporting the *Winters* decision rendered by the U.S. Court of Appeals for the Ninth Circuit. The *Winters* Court held that federal law requires denial of the health insurance benefits sought by Donna Winters. *Winters v. Costco Wholesale Group Benefits*, 49 F.3d 550 (9th Cir. 1995).

Other *Amicus Curiae* briefs may focus on discrimination against women in determining health insurance benefits and improper denial of insurance coverage for experimental treatments.

The NAIC's brief focuses on important questions of law and public policy which have not been adequately presented to the Court by the parties to this case or by other friends of the Court.

The focus of the NAIC brief is that the Ninth Circuit *Winters* decision should be reversed because the Ninth Circuit failed to apply state common law. The state common law doctrine of *contra proferentem* should have been applied because it is a well-established doctrine which protects health insurance policyholders and because it is not preempted by federal law. Furthermore, failure to apply *contra proferentem* frustrates the purpose of the Employee Retirement Income Security Act (ERISA) which

is to protect policyholders. ERISA, 29 U.S.C.A. § 1001(b) (1985). The NAIC brief explains insurance regulators' concerns that without this Court's review of the *Winters* decision, policyholders with traditional state-regulated policies will receive the benefit of *contra proferentem* while ERISA policyholders will not. This inequity is contrary to public policy and could even motivate employers to convert to ERISA plans simply to avoid state insurance laws.

THEREFORE, the NAIC respectfully requests permission to file the attached Brief *Amicus Curiae* in support of Petitioner, Donna Winters.

Dated the 17th day of
August, 1995

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INTEREST OF *AMICUS CURIAE*

The National Association of Insurance Commissioners (NAIC) is a non-profit, unincorporated association of the principal insurance regulatory officials of the fifty states, the District of Columbia, territories and insular possessions of the United States. The NAIC is interested in filing this brief in furtherance of its objectives to serve the public by assisting the several state insurance regulatory officials in improving state regulation of the business of insurance and promoting fair and equitable treatment of insurance policyholders and claimants.

Following a request from the Washington Insurance Commissioner, the Executive Committee of the NAIC, which consists of seventeen insurance commissioners from all regions of the country, recommended to the entire membership of the NAIC that the NAIC file a Brief *Amicus Curiae* in this case. Subsequently, the NAIC members adopted the recommendation and voted to file this Brief for several reasons that will be detailed herein.

The insurance commissioners have been charged by the McCarran-Ferguson Act, 15 U.S.C.A. §§ 1011, 1012, and by their own state statutes, *see, e.g.*, WASH. REV. CODE §§ 48.02.060, 48.02.080 (NILS 1995), to regulate the business of insurance. The insurance commissioners regulate many types and aspects of the business of insurance, including health insurance contracts. *See, e.g.*, WASH. REV. CODE §§ 48.18.010-48.18.540 (NILS 1995).

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. §§ 1001-1461 (1985) is a federal law that governs employer-sponsored health care plans. The United States Court of Appeals for the Ninth Circuit

held that ERISA preempts application of a particular state common law doctrine to the health insurance contract of Donna Winters. *Winters v. Costco Wholesale Group Benefits*, 49 F.3d 550 (9th Cir. 1995). The decision results in the unfair, undesirable and inconsistent application of rules of insurance policy interpretation: policyholders of traditional state-regulated health plans have the advantage of the common law rule of *contra proferentem, see*, George J. Couch, *Couch Cyclopedia of Insurance Law* 334 (1984), while according to the *Winters* Court, ERISA policyholders do not. *Winters v. Costco Wholesale Group Benefits*, 49 F.3d 550 (9th Cir. 1995).

The state insurance commissioners urge this Court to grant the Petition For a Writ of Certiorari, so that the Court may ultimately consider this case on its merits and eliminate the inequitable treatment of policyholders. The commissioners are interested in seeing this Court resolve the inconsistent application of *contra proferentem* so that all health care insurance consumers may enjoy the benefit of *contra proferentem*. Additionally, the insurance commissioners seek guidance from the Court regarding the scope of ERISA preemption of state common laws.

SUMMARY OF THE ARGUMENT

The *Winters* Court held that the state common law doctrine of *contra proferentem* should not be applied to the health insurance policy of Ms. Winters, the Petitioner. *Winters*, 49 F.3d 550. The result is that Ms. Winters' policy was construed against her and the coverage she sought was denied.

The NAIC argues that this Court should grant Ms. Winters' Petition for a Writ of Certiorari because the *Winters* decision should be reversed. *Contra proferentem* should be applied here because it is good law, well-established in every state to protect policyholders. ERISA does not specifically exempt state rules of statutory construction, and, in the absence of specific ERISA rules of construction, state rules should apply. In fact, *contra proferentem* is consistent with the purpose of ERISA, which is to protect policyholders.

If this Court grants the Petition for a Writ of Certiorari and ultimately renders a decision on the merits, insurance regulators, policyholders, and insurers will know what to expect from ERISA health plans. Failure to grant the Petition would mean regulators, policyholders, and insurers would remain uncertain as to whether or not *contra proferentem* applies to ERISA plans.

The NAIC argues that the Court should grant the Petition and ultimately render a decision on the merits so that policyholders of traditional state-regulated health plans and policyholders of ERISA plans all receive the benefit of *contra proferentem*. Finally, the NAIC urges the Court to grant the Petition and ultimately rule on the merits so that employers cannot take advantage of ERISA merely to avoid the state doctrine of *contra proferentem*.

ARGUMENT

I. This Court Should Grant the Petition for a Writ of Certiorari Because the *Winters* Decision Should Be Reversed.

The Ninth Circuit *Winters* Decision should be reversed because the court failed to apply the state common law rule of *contra proferentem*.

A. *CONTRA PROFERENTEM* SHOULD BE APPLIED BECAUSE IT IS WELL-ESTABLISHED COMMON LAW

Contra proferentem is the common law doctrine requiring that insurance contracts be construed against the insurer. George J. Couch, *Couch Cyclopedia of Insurance Law* 334 (1984). This doctrine is well-established in state common law. In fact, courts have almost unanimously held that "insurance contracts must be liberally construed in favor of a policyholder or beneficiary thereof, whenever possible, and strictly construed against the insurer in order to afford the protection which the insured was endeavoring to secure when he applied for the insurance." John and Jean Appleman, *Insurance Law and Practice* 197 (1976).

Contra proferentem has been specifically applied to ERISA plans. *See, e.g., Kunin v. Benefit Trust Life Insurance Company*, 910 F.2d 534 (9th Cir. 1990), which has been followed by eleven courts, according to Shepard's citations. In *Kunin*, the Ninth Circuit Court of Appeals specified that unclear or ambiguous policy terms should be construed in favor of the insured. *Kunin* at 535. The *Kunin*

health plan was an employee welfare benefit plan governed by ERISA, but the *Kunin* Court emphasized that federal programs governed by federal law "do not inevitably require resort to uniform federal rules." *Kunin* at 539, *citing U.S. v. Kimbell Foods*, 440 U.S. 715, 727-28 (1979). Relying on *Kimbell*, the *Kunin* Court held that state law can control federally governed controversies "either because Congress intends courts to look to state law, or because the incorporation of state law into the federal common law is appropriate. . . . " *Kunin* at 539.

In the *Winters* case, application of state common law is clearly appropriate because insurance has been historically regulated by the states, resulting in a well-established body of state case law that uniformly applies *contra proferentem* to policy interpretation. *See, e.g.*, Couch at 334-357. In 1945, Congress enacted the McCarran-Ferguson Act which dictates that the business of insurance and every person engaged therein shall be subject to the laws of the several states which relate to the regulation or taxation of such business. 15 U.S.C.A. § 1012. As a result, every state has developed comprehensive insurance laws that are enforced by state departments of insurance and interpreted by state courts. Therefore, we argue that application of the state doctrine of *contra proferentem* is appropriate within the meaning of *Kunin* and *Kimbell* because state courts have established a uniform body of law supporting such application while federal law is silent on the issue.

In fact, the *Kunin* court wrote that "it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule." *Kunin* at 540.

Furthermore, the rationale for *contra proferentem* is relevant to traditional health insurance policies as well as ERISA policies. More specifically, *contra proferentem* was developed because an insurer drafts the insurance policies and should not, therefore be "allowed to take advantage of the very ambiguities that it could have prevented with greater diligence" and that once a policy has been drafted, the insured does not have an opportunity to amend it. *Kunin* at 540. ERISA policies, like traditional health insurance policies, leave the insured with less bargaining power than the policy drafter. Therefore, the ERISA policyholder deserves the protection that *contra proferentem* provides.

B. ERISA DOES NOT PREEMPT APPLICATION OF *CONTRA PROFERENTEM*

ERISA generally subjects persons to state insurance, banking and securities laws. ERISA, 29 U.S.C.A. § 1144(b)(2)(A) (1985). However, employee benefit plans such as Costco's self-funded health insurance plan, shall not be deemed to be "engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." ERISA, 29 U.S.C.A. § 1144(b)(2)(B) (1985).

Despite the broad exemption language of the section quoted above, application of *contra proferentem* remains appropriate in this case because it is a common law doctrine which is not specifically exempted by ERISA. Additionally, ERISA fails to provide any guidance for interpretation of ambiguous health policy terms. In the

absence of specific provisions governing ERISA contract interpretation, the well-established body of state common law should apply, thereby implementing the doctrine of *contra proferentem*.

C. FAILURE TO APPLY *CONTRA PROFERENTEM* FRUSTRATES THE PURPOSE OF ERISA

ERISA begins with a section titled: "Congressional findings and declaration of policy." The first and third paragraphs of this section indicate Congressional interest in protecting interstate commerce and the Federal taxing power. The second paragraph illustrates Congressional interest in protecting policyholders:

> It is hereby declared to be the policy of . . . [ERISA] to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

ERISA, 29 U.S.C.A. § 1001(b) (1985).

Congress was obviously concerned with the welfare of participants in employee benefit plans. The ERISA declaration of policy cites protection of participants' interests as the motivating factor for enacting ERISA. The doctrine of *contra proferentem* is consistent with this goal. Application of *contra proferentem* in this case would

require that any ambiguous policy terms be construed in favor of Ms. Winters, the plan participant. Failure to apply *contra proferentem* would frustrate the intent of Congress and would be contrary to public policy. Therefore, it is important for this Court to grant the Petition for Writ of Certiorari so that the *Winters* decision can be reversed.

II. THIS COURT SHOULD GRANT THE PETITION FOR A WRIT OF CERTIORARI TO RESOLVE THE DISPUTE AMONG THE CIRCUITS

Rule 10 of the *Rules of the Supreme Court* specifies that this Court will grant a petition for a writ of certiorari "when there are special and important reasons therefore." The Rule then indicates that a split among United States courts of appeals is a factor the Court will consider when determining whether a petition sets forth adequate special and important reasons.

The Winters Petition for a Writ of Certiorari details the conflicting holdings of all the U.S. circuit courts. The Seventh and D.C. Circuits consistently apply *Contra proferentem* to ERISA insurance policies. Winters Petition for a Writ of Certiorari, pp. 12-19, *citing, e.g., McNeilly v. Bankers United Life Assurance Co.*, 999 F.2d 1199 (7th Cir. 1993) and *Germany v. Operating Engineers Trust Fund of Washington, D.C.*, 789 F. Supp. 1165 (D.C. 1992).

The Fourth and Eleventh Circuits apply *Contra proferentem* under *de novo* review and under discretionary review if the plan administrator is subject to a conflict of interest. Winters Petition for a Writ of Certiorari, pp. 20-30, *citing, e.g., Glocker v. W.R. Grace & Co.*, 974 F.2d 540

(4th Cir. 1992) and *Florence Nightingale Nursing Service v. Blue Cross/Blue Shield of Alabama*, 41 F.3d 1476 (11th Cir. 1995).

The Second and Sixth Circuits apply *contra proferentem* under *de novo* review only. Winters Petition for a Writ of certiorari, pp. 30-38, *citing, e.g., Masella v. Blue Cross & Blue Shield of Connecticut*, 936 F.2d 98 (2d Cir. 1991) and *Tolley v. Commercial Life Ins. Co.*, Nos. 92-6490, 92-6514, 1993 U.S. App. LEXIS 33508 (6th Cir. 1993).

The Eighth Circuit has held that ERISA preempts application of *contra proferentem* but has applied it when other tools of contract interpretation are not sufficiently helpful. Winters Petition for a Writ of Certiorari, pp. 39-40, *citing, e.g., Maxa v. John Alden Life Ins. Co.*, 972 F.2d 980 (8th Cir. 1992) and *Delk v. Durham Life Ins. Co.*, 959 F.2d 104 (8th Cir. 1992).

The Ninth Circuit applies *contra proferentem* unless the plan is self-funded and the administrator has discretion to interpret contract ambiguities. Winters Petition for a Writ of Certiorari, pp. 40-55, *citing, e.g., Kunin*, 910 F.2d 534 and *Winters*, 49 F.3d 550.

Finally, the four remaining circuits apply *contra proferentem* when review is *de novo* but they have not considered whether to apply it when reviewing a claim for abuse of discretion or when a plan is self-funded. Winters Petition for a Writ of Certiorari, pp. 55-58 (citations omitted).

The obviously inconsistent application of *contra proferentem* to ERISA insurance policies is worthy of this Court's review. Insurance regulators in the various states

are anxious to see *contra proferentem* applied consistently to ERISA policies. Furthermore, ERISA participants deserve the protections *contra proferentem* provides. In the absence of this Court's guidance, similar litigation will continue to clog the lower courts, leaving ERISA plan participants uncertain of their rights and remedies unless their cases are individually litigated.

III. THIS COURT SHOULD GRANT THE PETITION FOR A WRIT OF CERTIORARI TO PREVENT THE UNFAIR RESULT THAT SOME POLICYHOLDERS RECEIVE THE BENEFIT OF STATE RULES OF POLICY CONSTRUCTION WHILE OTHER POLICYHOLDERS DO NOT

When the NAIC members, the insurance commissioners from the various states, discussed the need to file a Brief *Amicus Curiae* in this case, one of their primary concerns was the existing potential for inequitable treatment of policyholders. *See*, NAIC Executive Committee minutes, June 4, 1995, reprinted in pertinent part in the Appendix to this Brief. The commissioners were concerned that some policyholders would receive the benefit of state rules for contract interpretation while other policyholders would not. *See*, NAIC Executive Committee Minutes, reprinted in pertinent part in the Appendix to this Brief. This inequitable treatment of policyholders could be eliminated if the Court granted the Petition and ultimately found that *contra proferentem* was applicable to ERISA plans.

IV. THIS COURT SHOULD GRANT THE PETITION FOR A WRIT OF CERTIORARI TO ULTIMATELY DISCOURAGE EMPLOYERS FROM PURSUING ERISA PLANS SIMPLY TO AVOID STATE RULES OF POLICY CONSTRUCTION

Another issue discussed by the insurance commissioners was concern that "many employers would abandon traditional insurers and utilize self-funded ERISA plans for health coverage because of the favorable application of federal law for the plans against the beneficiaries." *See*, NAIC Executive Committee Minutes, reprinted in pertinent part in the Appendix to this Brief.

In fact, one recent statistical analysis found that avoidance of state-mandated benefits and state premium taxes has previously been a motivating factor for employers to convert from traditional health plans to self-insured ERISA plans. Jensen, Cotter, Morrisey, *State Insurance Regulation and Employers' Decisions to Self-Insure*, in the *Journal of Risk and Insurance, Vol. 62*, 186, 185-213 (1995). It is certainly conceivable that a desire to avoid state common law rules, like *contra proferentem*, could similarly motivate employers to convert to ERISA plans. Such avoidance of state law is clearly contrary to public policy, contrary to the intent of ERISA, and potentially harmful to insurance policyholders.

CONCLUSION

Ms. Winters' Petition for a Writ of Certiorari should be granted so that the Court may ultimately consider this case on the merits. The decision on the merits would eliminate inconsistent application of *contra proferentem* to ERISA plans and ensure proper protection of all health insurance policyholders. For these and all other reasons detailed in this Brief, the National Association of Insurance Commissioners respectfully urges the Court to grant the Petition for a Writ of Certiorari.

Respectfully submitted,

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APPENDIX

NAIC Executive Committee
Minutes
June 4, 1995

. . . 13. Request for Brief of *Amicus Curiae* from Commissioner Deborah Senn (Wash.) in *Winters* v. *Costco*

John Woodall (Wash.) explained that the lawsuit for which the request for *amicus curiae* brief was being made was on appeal to the U.S. Supreme Court through a petition for *certiorari* filed on behalf of the plaintiff. He said that the opinion in the case, *Winters v. Costco*, provided an interpretation of the rule of *contra proferentem*, a principle of common law that provides that any ambiguity in an insurance contract is construed against the drafter of the contract – the insurer. The Ninth Circuit Court of Appeals found that this principle does not apply to certain self-funded Employee Retirement Income Security Act (ERISA) plans. He said that this finding places the Ninth Circuit in conflict with other circuit courts. He said that insurance regulators have an interest in resolution of this conflict because the decision created two tiers of contract interpretation for health coverages – one for consumers of traditional health insurers and one for consumers of self-funded ERISA plans. The inconsistency of these two standards would result in an inequitable treatment of consumers. Furthermore, he indicated that it would be possible that many employers would abandon traditional insurers and utilize self-funded ERISA plans for health coverage because of the favorable application of federal law for the plans against the beneficiaries.

Susan Martin (NAIC/SSO) indicated that the NAIC had previously taken positions supporting the primacy of

states in the regulation of insurance in several ERISA cases in which the NAIC had filed *amicus curiae* briefs in the last year. She noted that the filing of an *amicus curiae* brief in *Winters v. Costco* would be consistent with those previous positions. She noted that the deadline for filing the brief would be due in the U.S. Supreme Court on Aug. 11, 1995.

Upon motion duly made and seconded, the Executive (EX) Committee directed the NAIC legal staff to file an *amicus curiae* brief in the *Winters v. Costco* case.

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Amici curiae, the Northwest Women's Law Center, the California Women's Law Center, *et al.*, hereby move, pursuant to Rule 37.2, for leave to file a brief of *amici curiae* in support of the writ of certiorari to the United States Court of Appeals for the Ninth Circuit in *Winters v. Costco Wholesale Group Benefits Program, et al.* Petitioner has consented to the filing of this brief, but respondents have declined to consent. A copy of the proposed *amici brief* is attached.

INTEREST OF THE *AMICI CURIAE*

Amici curiae are 11 women's rights, civil rights and health care advocacy groups sharing a strong commitment to the protection of the rights of women and the assurance that women have equal access to health care and health insurance coverage. *Amici curiae* engage in litigation, legislation and education to assure that women are not discriminated against in the delivery of health insurance. Individual statements of interest of *amici* are as follows:

Northwest Women's Law Center

The Northwest Women's Law Center (the "Law Center") is a non-profit legal organization dedicated to advancing and protecting the legal rights of women through litigation, education, legislation and a legal information and referral phone line. The Law Center provides these services to women in Washington, Alaska, Montana, Idaho and Oregon. Since its founding in 1978, the Law Center has worked to ensure that women have access to health care and the protection of health care insurance in a non-discriminatory and equitable manner. The Law Center has worked on legislative initiatives on health care and insurance reform both locally and nationally. The Law Center has also participated as *amicus curiae* in several insurance discrimination cases throughout the country.

California Women's Law Center

The California Women's Law Center ("CWLC") is a private, nonprofit public interest law center specializing in the civil rights of women and girls. CWLC was established in 1989 to address the comprehensive civil rights of women and girls in the following areas: Sex Discrimination, Reproductive Rights and Health Care, Family Law, Violence Against Women and Child Care. The CWLC has placed a strong emphasis on addressing gender bias in health care. In addition, the CWLC has initiated the Breast Cancer Legal Clinic to provide advocacy and legal advice to breast cancer survivors and to address the systemic barriers that prevent women from accessing the health care they need and to which they are entitled. This case raises questions within the expertise and concern of the California Women's Law Center.

Employment Law Center a Project of the Legal Aid Society of San Francisco

The Employment Law Center ("ELC"), a project of the Legal Aid Society of San Francisco, is a private non-profit, public interest law firm which represents indigent workers in cases involving employment discrimination and workplace rights. The ELC specializes in, among other areas of the law, sex discrimination and employee benefits. Health coverage is an important employment benefit and the ELC is committed to insuring that women employees have access to non-discriminatory health insurance coverage.

Equal Rights Advocates, Inc.

Now in its twenty first year, Equal Rights Advocates is one of the country's oldest women's law centers dedicated to the empowerment of women through the establishment of their

economic, social and political equality. The organization has a long history of interest, activism, and advocacy in all areas of law which affect equality between the sexes. ERA has represented women in cases challenging lack of access to insurance benefits and joined as *amicus* in Title VII cases brought to assure equal treatment of the sexes in annuity plans.

Connecticut Women's Education and Legal Fund, Inc. (CWEALF)

The Connecticut Women's Education and Legal Fund, Inc. ("CWEALF") is a non-profit women's rights organization incorporated in 1973. We have over 1,400 members. Our mission is to work through legal and public policy strategies and community education to end sex discrimination and to empower all women to be full and equal participants in society. We seek to join this brief as *amicus curiae* because we support the need for increased medical research on women's health issues and understand that many women are excluded from lifesaving treatments because those treatments are deemed "experimental".

The Feminist Majority Foundation

Founded in 1987, the Feminist Majority Foundation is a 501(c)(3) non-profit organization with offices in Arlington, Virginia and Los Angeles, California. The Feminist Majority Foundation seeks to empower women through research, education, action and other strategies that bring about women's equality. The Feminist Majority Foundation believes that the precedent set in *Winters v. Costco* will have a significant negative impact on women's health care and that the ruling, as it presently stands, will have a disproportionately negative impact on women.

Lambda Legal Defense

Lambda is the nation's oldest and largest non-profit organization dedicated to the civil rights of lesbians, gay men and all people with HIV/AIDS. Since 1983 and its initiation of the first AIDS discrimination case, Lambda has had a strong, continuing interest and involvement in the development of fair and rational policies relating to HIV/AIDS, particularly in the area of insurance and access to health care. Because of the relatively short time during which HIV/AIDS has been recognized, and the limitations of HIV-related therapies currently approved by the Food and Drug Administration, the standard of care for HIV disease can include life-saving treatments for which studies documenting their efficacy are still in progress. Lambda believes that the failure to apply the long-established doctrine of *contra proferentem* to self-insured plans is inherently discriminatory and seriously detrimental to the lives and health of people with HIV disease who rely on these plans for their healthcare.

National Center for Lesbian Rights (NCLR)

The National Center for Lesbian Rights ("NCLR"), formerly the Lesbian Rights Project, is a non-profit public interest law firm founded in 1977 and devoted to the legal concerns of women who encounter discrimination on the basis of their sexual orientation. As a nationally recognized source of technical support and information on issues of lesbian health, NCLR is particularly well-suited to offer *amicus* assistance to this court in this matter. NCLR has published an extensive bibliography of research on lesbian health matters, which includes over eight hundred citations. NCLR is among the founders of the Washington, D.C. based Lesbian Health Advocacy Network, which provides information on women's access to health care, including its regulation by the insurance industry. We are regularly called upon

to provide information for federal health programs and for national conferences addressing women's health concerns.

National Black Women's Health Project (NBWHP)

The National Black Womens' Health Project ("NBWHP") is a self-help and health advocacy organization committed to improving the health of Black Women. The organization has 16 chapters and has members in 42 states. Studies have shown that women, especially women of color, often are given inferior information and fewer treatment options than others. The impact of these inequities result in disparate health outcomes and mortality rates. Therefore, NBWHP believes that patients and physicians should be allowed the widest possible latitude and choice in determining the best course of treatment. Insurance plan administrators should not be allowed absolute discretion in determining whether a treatment or procedure is "medically appropriate or necessary."

National Coalition for Cancer Survivorship (NCCS)

NCCS, a coalition of 2,500 individuals and organizations, represents tens of thousands of members and constituents in the cancer survivorship movement in the United States. NCCS members include leaders of cancer survivor community organizations, regional and national cancer-related organizations, and many of the nation's most prestigious cancer treatment institutions. Through public education and advocacy, NCCS works to expand the right to adequate health insurance to the nearly 9,000,000 cancer survivors of the United States.

National Women's Law Center

The National Women's Law Center is a Washington-based legal organization which has been working since 1972 to advance

and protect women's legal rights. The Center's primary goal is to ensure that public and private sector practices and policies better reflect the needs and rights of women. Access to quality health care and adequate health insurance is of profound importance to the lives of women throughout the country, and the National Women's Law Center has a long history of working to achieve that goal.

REASONS FOR GRANTING THE MOTION

Amici curiae are in a unique position to address the questions presented by this case and to bring additional reasons to the Court's attention why the writ should be granted. This case presents important issues of law that deserve the fullest and most informed discussion possible. *Amici* offer a particular expertise concerning the importance of this case to women and why it is important for this Court to grant review of the Ninth Circuit's opinion. The proposed brief of *amici curiae* explains the implication of the *Winters v. Costco* decision for women, describing the disproportionate impact the decision will have on women who are beneficiaries of health insurance plans under the Employee Retirement Income Security Act (ERISA). One significant result of the *Winters* decision is to make it easier for ERISA plan administrators to deny insurance coverage for medical treatments unless the treatments are supported by an abundance of scientific data. Consequently, women beneficiaries of ERISA plans will disproportionately suffer because, historically, research into women's health care has been under-funded and under-researched, resulting in a paucity of scientific data needed to support insurance coverage.

The brief of *amici* demonstrates the way in which the lack of funding and research of women's diseases has led to a lack of data and information about women's health care. It further demonstrates that if the Ninth Circuit decision in *Winters* is

upheld, this lack of data will lead to an increase in insurance coverage denials for women, particularly women in need of life-saving medical treatments. The brief of *amici* further explains how the *Winters* decision creates an unfair and unjust imbalance of power between insurance companies and insurance consumers and how the *Winters* decision makes an unprincipled distinction between beneficiaries of ERISA health plans and beneficiaries of private health care plans.

Amici contend that this brief includes information and arguments that are presented in neither the brief of petitioner nor the brief of respondent. *Amici* believe that the information and arguments will be meaningful and useful to this Court in weighing the implications of the *Winters* decision and in making the decision whether to grant the writ.

It is respectfully requested that the Court grant leave to file the attached brief of *amici curiae*.

Respectfully submitted,

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No. 95-116

In The

Supreme Court of the United States

October Term, 1995

DONNA WINTERS, an individual person,

Petitioner,

vs.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM and CONCEPT ADMINISTRATORS, INC.,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF *AMICI CURIAE* OF NORTHWEST WOMEN'S LAW CENTER, CALIFORNIA WOMEN'S LAW CENTER, CONNECTICUT WOMEN'S EDUCATION AND LEGAL FUND, EMPLOYMENT LAW CENTER A PROJECT OF THE LEGAL AID SOCIETY OF SAN FRANCISCO, EQUAL RIGHTS ADVOCATES INC., FEMINIST MAJORITY FOUNDATION, LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC., NATIONAL BLACK WOMEN'S HEALTH PROJECT, NATIONAL CENTER FOR LESBIAN RIGHTS, NATIONAL COALITION FOR CANCER SURVIVORSHIP, AND NATIONAL WOMEN'S LAW CENTER IN SUPPORT OF PETITION

INTEREST OF THE *AMICI CURIAE*

Amici curiae are 11 women's rights, civil rights and health care advocacy groups sharing a strong commitment to the protection of the rights of women and women's access to health care and health insurance coverage. *Amici curiae* engage in litigation, legislation and education to assure that women are not discriminated against in the provision of health insurance. Individual statements of interest of amici are set forth in the motion for leave to file a brief of *amicus curiae* in support of petition for writ of certiorari, submitted with this brief.

The case before the Court is of great importance to *amici* because of the disproportionate effect the Ninth Circuit ruling will have on women attempting to obtain health insurance coverage for important medical treatments and procedures.

STATEMENT OF THE CASE

This *amicus* brief supports Petitioner Donna Winters' brief in *Winters v. Costco Wholesale Benefits Program and Concept Administrators, Inc.*, 49 F.3d 550 (9th Cir. 1995), *petition for cert. filed*, 64 U.S.L.W. 3068 (U.S. July 18, 1995) (No. 95-116). For a review of the facts of the case and proceedings, the *amici curiae* respectfully refer the Court to the brief of the Petitioner. The *amici curiae* join Donna Winters in requesting that this Court grant the petition for review to resolve the current Circuit court split and determine whether and to what extent the doctrine of *contra proferentem* applies to insurance plans under the Employee Retirement Income Security Act (hereinafter "ERISA").

SUMMARY OF THE ARGUMENT

This case involves the standard of review that courts should

use when reviewing insurance coverage decisions made by ERISA insurance plan administrators. In *Winters v. Costco*, the Ninth Circuit rejected the long held doctrine of *contra proferentem* — the doctrine which requires courts to construe ambiguities in insurance contracts in favor of coverage for the beneficiaries — as it applies to ERISA health insurance plans. Consequently, the decisions made by plan administrators under ambiguous contract terms will be reviewed for an abuse of discretion only.

One result of this decision is that ERISA plan administrators will have broader discretion to deny insurance coverage for medical treatments unless the treatments are supported by an over-abundance of scientific data. *Amici* argue that women beneficiaries of ERISA plans will disproportionately suffer as a consequence of the *Winters* decision because, historically, research into women's health care has been under-funded and under-researched resulting in a paucity of the type of scientific data needed to support insurance coverage claims.

The brief of *amici* further argues that the *Winters* decision creates an unfair and unjust imbalance of power between insurance companies and insurance consumers and that the *Winters* decision makes an unprincipled distinction between beneficiaries of ERISA health plans and beneficiaries of private health care plans. *Amici* believe that the failure to apply the long-established doctrine of *contra proferentem* to ERISA health insurance plans is inherently discriminatory and seriously detrimental to the lives and health of women who rely on these plans for their health care coverage.

REASONS FOR GRANTING THE WRIT

I.

REJECTION OF THE DOCTRINE OF *CONTRA PROFERENTEM* FOR ERISA HEALTH PLANS WILL RESULT IN DECREASED COVERAGE FOR INSURANCE CONSUMERS AND WILL DISPROPORTIONATELY AFFECT WOMEN CONSUMERS DUE TO THE LACK OF DATA ON WOMEN'S HEALTH ISSUES.

A. The Rejection of the Doctrine of *Contra Proferentem* has a Disproportionate Effect on Female Beneficiaries of ERISA Health Plans.

The rule of *contra proferentem* states that courts are to construe ambiguities in insurance contracts in favor of coverage for the insured. *Kunin v. Benefit Trust Life Ins.*, 910 F.2d 534 (9th Cir. 1990). The doctrine was developed by courts to protect consumers of health insurance from ambiguous or unclear insurance contracts and to insure that the drafters of such contracts not be allowed to benefit from their own poorly drafted or deliberately vague contracts. The doctrine is important because it provides an incentive for insurance companies to describe with specificity what is covered or excluded in a contract and provides a disincentive to companies who might otherwise seek to disguise or make ambiguous those provisions that exclude coverage. The doctrine of *contra proferentem* allows insurance companies to draft their own contracts, but protects insurance consumers in the event coverage decisions are made pursuant to ambiguous exclusionary provisions. Consequently, the doctrine has been very important to consumers because it has helped put them on more equal footing with their insurance companies.

In *Winters*, the Ninth Circuit held that the rule of *contra*

proferentem does not apply to self-funded health plans under ERISA where the plan administrator has expressly reserved authority to determine benefit eligibility. Under *Winters*, beneficiaries of ERISA plans who are denied coverage under vague or ambiguous exclusionary provisions may successfully challenge the denial only if the insurance plan administrators are shown to have abused their discretion. If upheld, this ruling will result in consumers of self-funded ERISA plans having less access to coverage than many other health insurance consumers, who may retain the ability to challenge ambiguous exclusionary provisions under *contra proferentem*. There is no principled basis for this distinction between consumers whose health insurance is under an ERISA plan, and those whose health insurance is private.

In particular, this decision will have a disproportionate impact on women because treatments for women's health issues[1] are more likely to fall into the contested area of ambiguous exclusionary provisions. Typically, insurance companies exclude from coverage treatments defined as "experimental and/or investigational," or "not medically necessary." Whether a particular treatment or procedure will be included under one of these exclusionary provisions is generally determined by the availability of medical data to support the efficacy of a particular treatment. Michael R. Testerman, Legal Challenges to Denials of Insurance Coverage for "Experimental Medical Treatments", 89 Mo. Med. 4 (1992). Because women's health issues have been historically under-researched, resulting in a paucity of medical data, women seeking medical treatments are disproportionately the targets of insurance companies seeking to invoke ambiguous exclusionary provisions such as "experimental and/or

1. Women's health issues have been defined as "diseases or conditions that are unique to women, are more prevalent or more serious in women, or for which specific risk factors or interventions differ for Women." H.R. 5393, 101st Cong. 2d. Sess. (Women's Health Equity Act of 1990).

investigational," or "not medically necessary."[2] The lack of research and data on women's health issues also makes it more difficult for women to challenge denials under one of these exclusionary provisions. This is true because plan administrators need only show that the denial was not an abuse of discretion and do not need to show that it was reasonable. The discretion given to plan administrators under *Winters* will result in women having a higher susceptibility to coverage denials and a decreased ability to successfully challenge these denials.

Under *Winters*, women will disproportionately suffer from the loss of protection provided by the doctrine of *contra proferentem* because plan administrators, acting on behalf of insurance companies, will be virtually unchallenged when they assert that there is not enough medical data to establish that a particular treatment is appropriate. Prior to *Winters*, women beneficiaries were able to challenge a contract's ambiguous provisions to compel coverage for cancer treatments — primarily for breast and ovarian cancer — through the doctrine of *contra proferentem*. These women beneficiaries being denied coverage were given the opportunity to present medical evidence to demonstrate that the treatment they were seeking did not fall under a particular ambiguous exclusionary provision and that it had efficacy for the particular illness. The practical result of the *Winters* holding is that insurance plan administrators will now have virtually complete discretion to make determinations

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2. In making these decisions, the insurer essentially renders a determination that either the insured's proposed treatment is not an appropriate remedy for the condition or the condition does not require the medical attention requested by the insured. It should be noted that insurers often issue denials despite the recommendation for treatment by the treating physician and an insufficient claims review process. Thus, if a particular treatment is not known to produce a cure or satisfactory result for a particular condition, it may be deemed "experimental," "investigational," and/or "not medically necessary" and accordingly not covered. Testerman, 89 Mo. Med. 4.

regarding coverage issues, short of an abuse of discretion, and the lack of data regarding women's health issues will mean decreased coverage for women.

B. Women's Health Issues Have Been Historically Under-Funded and Under-Researched, Resulting in Relatively Limited Medical Data.

Until recently, women's health issues have received scant attention from the scientific, medical, and political communities. 100 U.S. Pub. Health Service 73 (Women's Health: Report of the Public Health Service Task Force on Women's Health Issues) (1985); Cynthia Costello and Anne J. Stone eds. (W.W. Norton 1994), The American Woman: Where We Stand; Judith H. LaRosa and Vivian W. Pinn, Gender Bias in Medical Research, 48 J. Am. Med. Women's Ass'n 5 (1993). Public health experts as well as the federal government have now acknowledged and criticized the under-funding and lack of attention paid to women's health issues and the widespread exclusion of women from important medical study groups. *Id.* The impact of this neglect has resulted in an absence of research data available to support insurance coverage for the treatment of women's illnesses.

The first large scale documentation of the neglect of women's health research was a 1985 report by the Public Health Service Task Force on Women's Issues detailing the health status of American women. The Task Force was convened in response to a concern that women's health issues were being under-researched and that women were being excluded from clinical drug trials. *Id.* The Task Force Report concluded that lack of data on women resulted in a limited understanding of women's health care needs and the medical services women require. *Id.* The Report recommended that "... a systemic effort be made to address issues relating to gender bias in research and clinical

practice," and that, "biomedical and behavioral research be expanded to ensure emphasis on conditions and diseases unique to, or more prevalent in, women in all age groups." *Id.*

In response to the Task Force Report, the National Institutes of Health (NIH) "promulgated a policy to ensure that women were included in study populations." *Id.* at 5. Unfortunately, the NIH has made little progress towards this goal. A 1990 Government Accounting Office (GAO) report concluded that the NIH had done very little to implement its own policy and that women's health was still under-researched. National Institutes of Health: Problems for Implementing Policy on Women in Study Populations: Hearings Before the Subcomm. on Health and the Environment of the Comm. on Energy and Commerce, 101st Cong., 2d Sess. (1990) (statement of Mark V. Nadel, Assoc. Dir., National and Public Health Issues Human Resources Division), at 2. Under-funding has contributed to the inability to provide substantial amounts of data on the appropriate treatments for diseases primarily affecting women.

Following the 1985 Public Health Service Report, the Women's Health Advisory Committee issued a report in 1987 which detailed an institute by institute account of resources committed to women's health. Comprehensive Report of the Office of Research on Women's Health, U.S. Dept. Of Health and Human Services at 1. The Committee calculated that only 13.5% of the NIH overall budget in 1987 went to women's health research. *Id.* The NIH is the principal federal agency supporting biomedical research. National Institutes of Health: at 2.

> [N]ot only were women being left out of research on diseases that affect both sexes, but just 13.5% of the total NIH budget was being used to look at breast cancer, all gynecological cancer, infertility, pregnancy

> and contraception. Conditions such as fibroid tumors of the uterus, endometriosis, menstrual cramps, and premenstrual syndrome — all of which are quite common — were being virtually ignored. And diseases such as arthritis, Alzheimer's, and osteoporosis — which primarily affect women — were also being shortchanged.

Leslie Laurence and Beth Weinhouse, *Outrageous Practices: The Alarming Truth About How Medicine Mistreats Women* (1994).

Today breast cancer remains the most common form of cancer in women, and the second leading cause of cancer related deaths. H.R. 5393 (Women's Health Equity Act). One in eight women in the United States will be diagnosed with breast cancer during her lifetime. Jay R. Harris, *et al.*, Medical Progress: Breast Cancer, 327 New Eng. J. Med. 319 (1992). The risk of breast cancer has increased exponentially, more than doubling since 1960. African American women have experienced a steadily increasing mortality rate which has exceeded that of white women. *Id.* As recently as 1989, only $77 million was budgeted for all breast cancer research and of this amount, only $17 million was spent on basic research which focuses on the origins of the disease. H.R. 5393 (Women's Health Equity Act). While the total dollars dedicated to breast cancer research have increased significantly from 1991-1994, breast cancer research still consists of less than 9% of the National Cancer Institute's total cancer research budget. Cancer and AIDS Research Funding Trends, National Cancer Institute Financial Management Branch, 1994 Bypass Budget Request.

Such studies confirmed the general lack of funding and attention paid to women's health issues and specifically identified a critical area of discrimination — women have

systematically been excluded from clinical studies in nearly all areas of general medical research.[3] National Institutes of Health: at 2; Costello & Stone at 91-108. Even when efforts were made to include women in study groups, women were not included in relevant numbers and the data was not analyzed in a manner that would reveal the particular health effects on women. R.B. Merkatz, *et al.*, Women in Clinical Trials of New Drugs: A Change in Food and Drug Administration Policy, 329 New Eng. J. Med. 292, 293 (1993). In 1977, Food and Drug Administration (FDA) guidelines stated that "in general, both sexes [should have] substantial representation in clinical trials before FDA approval of drugs". *Id.* Despite adequate participation by both men and women, however, the data from the female participants was never isolated and analyzed to determine whether there were gender differences in the data. *Id.* The absence of such analysis undercuts any of the potential benefits of female participation in these clinical trials.

Further, the 1977 FDA guidelines on the participation of women in drug evaluations excluded a majority of the female population because it specifically excluded virtually all women with "child-bearing potential" from everything but the final phases of drug studies.[4] *Id.* Only after the FDA had sufficient

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3. Various justifications have been cited for this wholesale exclusion of women, including the complexity and cost of accounting for women's hormonal cycles, the availability of identifiable, convenient cohorts such as veterans or army recruits who are primarily male, and the concern that women in their childbearing years may become pregnant and expose the fetus to potential risks. Judith H. LaRosa and Vivian W. Pinn, *Gender Bias in Medical Research*, 48 J. Am. Med. Women's Ass'n 5 (1993).

4. Women fitting this definition included (1) pre-menopausal women who were sexually active and using no contraception; (2) women who were using oral, injectable or mechanical contraception; (3) women whose partners had vasectomies; (4) women who were sexually inactive; and (5) lesbians. R.B. Merkatz, 329 New Eng. J. Med. 292.

analysis as to the safety of a new drug could women with the capacity to become pregnant participate in later phases of studies. Only women with life-threatening diseases were allowed to participate in the early phases of drug trials. Most often, the justifications behind the exclusion were the legal and ethical issues surrounding the potential exposure to the fetus. Anna C. Mastroianni, *et al.* Eds., Women & Health Research, Ethical & Legal Issues of Including Women (National Academy Press 1994). Notwithstanding recent FDA changes in these practices, women's research remains underdeveloped. As a result, treatment for certain diseases is susceptible to being challenged as "experimental and/or investigational" by plan administrators, on behalf of insurance companies, seeking to limit the cost of providing health care benefits to their insureds.

As a result of the traditional rationales for excluding women from drug testing, researchers have excluded women from many clinical trials in which the need for their inclusion would seem self-evident. For example, cardiovascular disease is the number one cause of death and disability in American women, and yet women have been excluded from almost all major clinical trials on heart disease. R.B. Merkatz, at 64. In a leading study of coronary heart disease, known as the Lipid Research Clinic-Coronary Primary Prevention Trial, that ran from 1967 to 1983, women were excluded entirely, in part because it would have increased the cost of the study. LaRosa and Pinn at 147. The seminal study of the use of aspirin as a preventative therapy for coronary disease, The Physicians Health Study, included 22,701 men and no women. Laurence and Weinhouse at 61. The Multiple Risk Factor Intervention Trials, known as the Mr. Fit study, used a population of 13,000 men and no women to do a long term study of lifestyle factors related to cholesterol and heart disease. Laurence and Weinhouse at 61. As a result, doctors and scientists still do not know whether dietary change and exercise can benefit women in preventing heart disease. *Id.*

Women were even excluded for the first 20 years of the country's most significant study to date regarding aging, despite the well-established fact that women on average live longer than men.[5] *See* Normal Human Aging, the Baltimore Longitudinal Study (Bethesda, MD: US Dept. Of Public Health, 1994) NIH Publication #84-2450.

The nature of AIDS and the status of AIDS research, particularly in the treatment of women, underscores the dangers of endorsing a standard of review that effectively precludes the insured's ability to challenge the denial of coverage under "experimental and/or investigational" exclusions. Many treatments for AIDS are still the focus of continuing investigation, while others are rapidly developing. Mark Scherzer, Insurance and AIDS (16.05[2], 16-25, in Sexual Orientation and the Law, Release #7 (Nov. 1994). As a result, treatment of those with HIV disease often requires the use of therapies known to be effective long before there is an abundance of formal data to support the efficacy. National Commission on Acquired Immune Deficiency Syndrome, HIV Disease in Correctional Facilities (March 1991) at 14.

The lack of formal data supporting the use of effective AIDS treatments is of particular concern to women because the participation of women in AIDS clinical research is disproportionately low. Since funding of AIDS research began around 1982,[6] almost all funding and research on AIDS has been directed towards men.[7] As of early 1993, 21,598 people were

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5. A 1992 study by the National Center for Health Statistics indicates that a female's life expectancy at birth is almost seven (7) years longer than a male's life expectancy. Costello and Stone at 111-15.

6. National Cancer Institute Research Dollars by Variuos Cancer, Updated March 1995.

7. While some clinical research has focused on women as subjects, the (Cont'd)

enrolled in U.S. AIDS Clinical Trial Group studies, but only 1,952 were adult women. J. A. Koruck, Trends in Federally Sponsored Clinical Trials, Until the Cure: Caring for Women with HIV (Yale University Press 1993). When the Food and Drug Administration approved the AIDS drug AZT in 1987, not one of the sixty-three federally funded studies had evaluated the drugs toxicity or efficacy in women. Laurence and Weinhouse at 5. This exclusion is particularly alarming in view of the fact that women are the fastest growing population group afflicted with AIDS and AIDS related illnesses have been the fourth leading cause of death among U.S. women ages 25-44 since 1992.[8]

The chronicle of the exclusion of women from medical studies underscores the disadvantages facing women who seek to present medical data to challenge a denial of coverage. Due to the exclusion of women from clinical trials, women are more likely to need treatments that are subject to ambiguous exclusionary labels such as "experimental and/or investigational," than are men for whom substantial medical data exists. 100 U.S. Pub.

(Cont'd)
primary research inquiry has been how to reduce or prevent a vertical transmission of the virus from a pregnant woman to a fetus or newborn and not how to treat the female specific manifestation of the disease. NIH Support For Research on Women's and Men's Health Issues Fiscal Years 1988, 1989, 1990, U.S. Department of Health and Human Services, Public Health Service, National Institute of Health, NIH Publication No. 92-3456 July 1991; CDC HIV/AIDS Prevention Fact Sheet, February 13, 1995. Women and Health Research, p. 66.

8. Through December 1994, the Centers for Disease Control and Prevention ("CDC") received reports of 58,428 cases of acquired immunodeficiency syndrome ("AIDS") among adult and adolescent (13 years and older) women in the United States. The population of women among cases in adults and adolescents has increased steadily, from 7 percent in 1985 to 18 percent in 1994. CDC HIV/AIDS Prevention Newsletter, Facts About Women and HIV/AIDS, February 13, 1995.

Health Service 73. If *Winters* is upheld, elimination of the doctrine of *contra proferentum* coupled with the lack of data pertaining to women's health issues will result in an increased denial of coverage for treatments for women. Women consumers challenging these decisions, even when based on ambiguous policy terms, will succeed in obtaining coverage only when plan administrators are found to have abused their discretion.

The neglect of women's health issues also increases the likelihood that insurance companies will exclude health care services for women based on a determination that a treatment is "not medically necessary." The *Winters* decision allows ERISA plan administrators to be, in effect, the sole arbiters of what is medically necessary. The current trend of insurance carriers towards discharging mothers and their babies within as little as eight hours after delivery illustrates risks involved when insurance companies and not doctors decide what is medically necessary. Despite the fact that there is little research to evaluate the health effects of early discharge policies, insurance companies have determined that longer stays are not medically necessary. Paula Braveman, *et al.*, Early Discharge of Newborns and Mothers: A Critical Review of the Literature, Pediatrics (forthcoming August, 1995 in the Periodical of Pediatrics). By reducing the length of hospital stays for mothers and babies, insurance companies have reduced the cost of care. Since maternity care is routinely covered in almost all insurance plans, the financial decision to reduce the length of stays under the ambiguous "not medically necessary" exclusions is having an enormous effect nationally on the health care that women and their newborn babies receive. The lack of data evaluating the impact of early discharge from the hospital will make such practices virtually impossible to challenge without the doctrine of *contra proferentem.*

Failure to apply the doctrine of *contra proferentem* to ERISA

plans is inherently discriminatory and seriously detrimental to the lives and health of women.

II.

IF THE NINTH CIRCUIT OPINION IS UPHELD, WOMEN WILL BE UNIQUELY DISADVANTAGED UNDER THE ARBITRARY AND CAPRICIOUS STANDARD.

The doctrine of *contra proferentum* is needed as a threshold presumption for the purposes of creating a more equitable balance of power between the insurer and the insured. Without the doctrine, ERISA plan administrators have virtually complete discretion under an arbitrary and capricious (*i.e.* abuse of discretion) standard of review. Women in particular are at greater risk than men for denials of medical benefits for insurance coverage, as a result of the paucity of medical knowledge of women's health issues for the reasons more fully set forth in Point I, *supra.* Plan administrators, even though charged with a fiduciary responsibility, are only found to have abused their discretion when they fail to meet the arbitrary and capricious standard of review mandated by *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S. Ct. 948 (1989). As demonstrated below, bound only by the arbitrary and capricious standard of review, courts have been forced to uphold decisions made by plan administrators even when the decisions conflicted with leading medical evidence, were inconsistent with prior company decisions, or were made pursuant to vague and unclear contract provisions.

This arbitrary and capricious standard requires that the court give deference to the decision of the plan administrator provided that the decision was not made arbitrarily. *Id.* According to *Firestone*, when the administrator is also the insurer and operates

under a conflict of interest, a less deferential scope of review is afforded. *Id.* However, even when this less deferential standard of review is applied, plan administrators regularly deny coverage under ambiguous exclusionary provisions. As a result, there has been much litigation initiated by women regarding benefit denials and, in particular, the cases involve a medical procedure known as high dose chemotherapy with autologous bone marrow transplant ("HDC/ABMT") used to treat breast cancer. *See, White v. Caterpillar, Inc.*, 765 F. Supp. 1918 (W.D. Mo. 1991); *Adams v. Blue Cross/Blue Shield of Maryland*, 757 F. Supp. 661 (D.C. Md. 1991); *Bucci v. Blue Cross/Blue Shield of Connecticut, Inc.*, 764 F. Supp. 728 (D. Conn. 1991). In those circuits in which the doctrine of *contra proferentem* is not law, litigants have lost the benefit of a threshold analysis which favors the insured.

William P. Peters, M.D., Ph.D., M.B.A, the Director of the Duke University Bone Marrow Transplant Program, one of the premier institutions in the country, and Mark C. Rogers, M.D., M.B.A., examined the consistency of preauthorization decisions by insurance companies for 533 women with breast cancer requiring HDC/ABMT from 1989 through 1992 (the "Duke Study"). William P. Peters and Mark C. Rogers, Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer, 330 New Eng. J. Med. 473 (1994). Preauthorization of payment for the medical procedure is generally required by the hospital prior to admission. Of these patients, 23% received denials by the insurers utilizing exclusionary provisions contained in the health insurance contract excluding coverage for women enrolled in clinical research trials (*i.e.* "experimental and/or investigational" treatment). The Duke Study concluded that ". . . [w]ith many insurers the outcome of the predetermination process [for HDC/ABMT for breast cancer] varies from request to request [and] is particularly disconcerting." *Id.* The study also concluded that the predetermination process, as applied to these breast cancer survivors, was "arbitrary and capricious" and that the ". . . process of predetermination by insurers did not correlate with protocol-based

medical decisionmaking, and it was a barrier to obtaining treatment." *Id.* Inasmuch as many of these women were catastrophically ill with breast cancer and had to thus suffer additional anguish and despair in coping with denials of coverage for life saving medical treatment, the plan administrators' arbitrary denials render such conduct unconscionable and certainly in breach of the fiduciary responsibility mandated by ERISA.

In *Holder v. Prudential Insurance Company of America,* 951 F.2d 89 (5th Cir. 1992), plaintiff was the beneficiary of a Prudential health insurance policy by virtue of his employment. Plaintiff's wife, also a beneficiary under the policy, was first diagnosed with breast cancer in 1987. The tumor and surrounding tissue were surgically removed shortly thereafter. After receiving standard dosages of chemotherapy, Mrs. Holder's cancer reoccurred a few months after the surgery. Her doctors suggested that she undergo HDC/ABMT. The terms of the insurance policy provided that the plan administrator had discretion to construe and interpret the plan provisions. The insurer in *Holder* denied plaintiff coverage based on the "experimental" term in the exclusionary portion of the summary plan description. As has been generally acknowledged, benefits for medical coverage are deemed to be within the grant of coverage of a plan unless specifically excluded. Utilizing the applicable arbitrary and capricious standard of review, the court completely deferred to the decision of the administrator.

In *Holder* the insurer routinely paid for chemotherapy to treat breast cancer, and indeed had paid for previous chemotherapy for Mrs. Holder. The plan neither limited the amount of chemotherapy to which Mrs. Holder was entitled, nor specified the drugs approved for her use thus creating ambiguity. Despite this patent ambiguity, when coverage for HDC/ABMT was sought, the denial was upheld by the court. Had *contra proferentem* been utilized, the court's inquiry would have been focused on the reasonableness of the administrator's construction of the ambiguous policy terms. Absent the benefit of the doctrine, the abuse of discretion standard supported

the insurance company's position that its denial of coverage was justified.

Likewise, in *Thomas v. Gulf Health Plan, Inc.*, 688 F. Supp. 590 (S.D. Ala. 1988), plaintiff Janice Thomas was diagnosed with breast cancer, and she immediately underwent surgery. The cancer reoccurred and Mrs. Thomas' physician treated her further with eight cycles of various chemotherapy drugs. Once the cancer failed to respond to this regime, Mrs. Thomas' physician recommended that she receive HDC/ABMT. The defendant insurance company precertified the costs associated with the bone marrow harvesting and the three day hospital stay. Thus, part of the treatment was covered. The plan administrator, however, later denied the plaintiff's request for coverage, under an ambiguous exclusion which denied insurance coverage for "experimental" treatments. The court upheld the denial stating that the decision was ". . . rational and [made] in good faith". The court also stated that "[i]t is undisputed that, as it relates to the treatment of breast cancer, [HDC/ABMT] is experimental." The fact that the same insurance company, operating under the identical plan, had paid for this treatment in the past was given no importance. Inconsistency in applying the terms of an insurance plan is evidence of an ambiguous contract and yet the *Thomas* court deferred to the decision of the administrator in upholding the claims denial. Had *contra proferentem* been applied, the decision would have clearly favored Mrs. Thomas thereby protecting her from the contracts ambiguity. Again, the arbitrary and capricious standard was insufficient to protect the rights granted to Mrs. Thomas. *See also*, *Lowery v. Healthchicago Inc.*, 1994 U.S. Dist. Lexis 6380 (N.D. Ill. 1994) (where the court upheld the plan administrator's denial of plaintiff's request for coverage despite the insurer's failure to adequately review the request for coverage under its own internal guidelines).

In *Bechtold v. Physicians Health Plan of Northern Indiana, Inc.*, 19 F.3d 322 (7th Cir. 1994), an ambiguity in the policy was created by

cross-referencing another manual to define its terms without providing the beneficiary with a copy of that manual. The spirit of ERISA, mandating full disclosure of all insurance policy provisions, was ill served by this omission. The court held that ". . . the clear and unambiguous language of the policy dictates that the defendant . . . properly denied coverage for the HDC/ABMT treatment." *Id.* at 325. Certainly, since the summary plan description incorporated terms of another plan, which was not given to Mrs. Bechtold, the exclusion of HDC/ABMT as a treatment for breast cancer was anything but "clear". Mrs. Bechtold, a forty-two year old woman, whose cancer reoccurred after having a modified radical mastectomy, clearly needed to have the playing field leveled. The doctrine was needed to protect her from contract provisions which deliberately created an ambiguity. By supplying its insureds with only half of the contractual terms, the defendant maintained complete supremacy and gave itself authority to make post hoc coverage determinations by keeping insureds ignorant of the meaning of the policy terms.

Similarly, in *Johnson v. District 2 Marine Engrs. Ben. Assn.*, 857 F.2d 514 (9th Cir. 1988), the plan administrator denied plaintiff's request for a liver transplant, which was her only chance for survival. The contract was initially silent about coverage for transplants. Following the submission of Mrs. Johnson's request, the insurance company amended the policy to specifically exclude organ transplants. The court held that there was no arbitrary conduct since the administrator stated that it was never the Plan's intention to include the cost of transplants within the scope of coverage. The court further noted that the precarious state of the insurer's finances compelled the administrator to exclude transplants from coverage. It reasoned that given the financial status of the company, it could not possibly have intended to include the cost of transplants as a covered expense. Essentially, by reaching this conclusion, the court implied that the insured should be able to determine the intent of the plan's drafters, even where such intent was not stated in the terms of the plan. This case is illustrative of the dire need for a balancing of the

equities between the insurer and insured. The doctrine of *contra proferentem* would have protected Mrs. Johnson against this arbitrary denial. Because transplants were not specifically excluded from coverage, any ambiguity would have been construed against the insurer. By failing to apply this doctrine, the court essentially approved the practice of orally amending insurance contracts to exclude coverage for treatment after a request for a payment. This holding, as well as the aforementioned, violates the spirit of ERISA which was enacted to guarantee the benefits promised to employee beneficiaries and their families.

CONCLUSION

For the foregoing reasons, this Court should hold that the doctrine of *contra proferentem* applies to decisions made by ERISA plan administrators.

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NO. 95-116

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1995

DONNA WINTERS, an individual person,

Petitioner,

v.

COSTCO WHOLESALE GROUP BENEFITS PROGRAM and CONCEPT ADMINISTRATORS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, NINTH CIRCUIT

REPLY TO RESPONDENTS

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MISCELLANEOUS

Sharon Begley, *The Baby Myth*, Newsweek, Sept. 4 1995 9

I. INTRODUCTION

For decades, insureds in all 50 states and the District of Columbia have enjoyed the protection of contra proferentem. *See, e.g. Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir. 1990), *cert. denied,* 498 U.S. 1013 (1990), *reh'g denied,* 498 U.S. 1074 (1991); Amicus Brief of NAIC at pages 4 - 6. This common law doctrine requires ambiguous terms in insurance policies to be construed in the insured's favor where the term reasonably covers the insured's claim.

The reason for this doctrine is simple fairness: since the insurer drafts its policy without input from the insured, and since the insurer's knowledge and drafting experience far exceeds

the insured's, the insurer should not be allowed to take advantage of any ambiguities it creates. *Id.*

In 1974, Congress enacted ERISA. Its purpose was threefold: to give participants in employee health benefit plans greater protection than they enjoyed under the common law; to clarify the scope of their insurance coverage; and to promote uniform insurance regulation. *See, e.g. Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989); *Aloha Airlines, Inc. v. Ahue,* 12 F.3d 1498, 1501 (9th Cir. 1993); ERISA, 29 U.S.C.A. § 1001(b). Since 1990 federal courts have been struggling to determine whether ERISA plan participants enjoy the protection of contra proferentem

which they enjoyed prior to ERISA, under the common law.

The circuits' struggle does not arise where the insurer has *not* given itself the power to interpret ambiguities, in other words, under de novo review. All circuits apply contra proferentem in such cases.

Paradoxically, the circuit dispute is whether contra proferentem applies where the insurer gives itself the power to interpret ambiguities, in other words, under discretionary review. Even more paradoxically, the Ninth Circuit in *Winters* has refused to apply contra proferentem under discretionary review if the plan is self-funded; stated differently, the Ninth Circuit *does not* apply contra proferentem where the employer is

the insurer and has given itself the power to interpret the plan.

The paradox is that insureds need *more* protection, not less, where the employer drafts the policy and also has the power to interpret ambiguities. Such an employer (who is a fiduciary to its employee/insured), faces an enormous conflict of interest, because it can increase its bottom line by refusing to pay claims arising under ambiguous policy terms. The insured, inexperienced in deciphering technical policy terms, does not know her coverage is inadequate until it is too late. Thus, the employer-as-insurer can lure quality employees with seemingly broad coverage, and then cut them off at claim time.

Petitioner asks this Court to resolve the paradox and settle the cir-

cuits' dispute by ruling that contra proferentem applies to all insurance contracts under ERISA. Application of contra proferentem will eliminate an employer's conflict of interest and its resulting incentive to draft ambiguous policies by holding the employer responsible if the insured's claim is reasonably within the scope of an ambiguous policy term. Application of contra proferentem will thus supplement ERISA's goals of protecting employees and clarifying the scope of their insurance coverage.

In addition, application of contra proferentem under ERISA will promote uniformity of insurance regulation. Presently, to decide whether to apply contra proferentem, courts must distinguish between non-ERISA and ERISA poli-

cies, between policies under de novo review and policies under discretionary review, and between indemnification plans and self-funded plans. A ruling that contra proferentem applies to all insurance policies will eliminate this patchwork and provide ERISA plan participants the same protection as their non-ERISA counterparts. *See also* Amicus Brief of NAIC at pages 10 - 11.

II. REPLY TO RESPONDENTS

A. An Administrator Abuses its Discretion by Interpreting Ambiguities Against the Insured.

Contra proferentem is related to the abuse of discretion standard in that an administrator abuses its discretion by interpreting ambiguous plan terms against the insured. Respondents dispute this, arguing that contra proferen-

tem and abuse of discretion are "unrelated concepts." Respondents' brief at page 8.

Respondents' argument derives from erroneously equating the abuse of discretion standard with the administrator's factual investigation. In fact, the investigation, like the duty to apply contra proferentem, is a *subset* of the overarching abuse of discretion standard: the latter applies when the policy is ambiguous, and the former applies when the policy is not ambiguous. Thus, when an administrator construes an ambiguous policy term, contra proferentem requires him find coverage without conducting an investigation, as long as the ambiguous term reasonably includes the insured's claim. Otherwise, the administrator abuses his discretion.

Respondents acknowledge this in their brief at footnote 2, page 8, but argue that courts, not administrators, should apply contra proferentem. Respondents' position would create an inefficient claims dispute process, because it would force insureds to litigate in order to obtain the benefit of contra proferentem.

In contrast, if the administrator applies the contra proferentem principle, the insured prevails (provided her claim is reasonably within the ambiguous term) and does not have to sue to receive health benefits. Contra proferentem therefore should be applied from the outset, by the administrator, to encourage prompt and inexpensive resolutions of claims disputes.

B. Contra Proferentem Requires the IVF Exclusion to be Interpreted in Petitioner's Favor.

In refusing to reimburse Winters for her GIFT procedure, Costco argued that its policy's IVF exclusion is ambiguous; that Costco has the right to interpret policy ambiguities; and that, under its interpretation, "IVF" includes GIFT.

Assuming Costco correctly claims "IVF" is ambiguous,[1] it still cannot prevail. This is because Costco should

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[1] Petitioner maintains, and the District Court agreed, that the term "IVF" unambiguously *excludes* GIFT. *Winters v. Costco,* No. C92-581WD (W.D. Wash. July 26, 1993), App. B at 11-16. *See also* Sharon Begley, *The Baby Myth,* Newsweek, Sept. 4 1995 at 41.

have interpreted the "ambiguous" IVF exclusion in favor of coverage. If this Court agrees, and applies contra proferentem to "IVF," Winters will recover benefits because contra proferentem dictates that "IVF" be construed in Winters' favor. Winters therefore has a personal stake in this litigation.

Respondents deny Winters' personal stake. They claim Winters cannot recover even if this Court applies contra proferentem, because of the Ninth Circuit's erroneous ruling that Costco's benefits denial was based on a reasonable investigation.

Respondents' argument is incorrect because it assumes an employer's investigation is pertinent to the interpretation of an ambiguous policy term such as Costco's IVF exclusion. In fact, the

investigation is pertinent only if the term is *unambiguous*. Contra proferentem applies where the term is ambiguous, and dictates that the insured prevail if the ambiguity reasonably covers her claim.

To allow the investigation to provide a basis for interpreting an *ambiguous* term is to allow the employer to retroactively alter the insurance contract to the detriment of the insured. This would be manifestly unfair. The employer-as-insurer implements its interests during the drafting process. The insured does not participate in the drafting, and is offered the policy on a take-it-or-leave-it basis. To permit the employer to interpret ambiguous terms in its own favor effectively permits the employer to continually improve

its already one-sided policy at the insured's expense.

Rather, the purpose of the investigation is not to interpret the policy, but instead to gather facts about the insured's situation and apply them to the policy to determine if the insured's claim falls within an *unambiguous* policy provision. In *Winters,* for example, Costco's Administrator's "investigation" (which was perfunctory and superficial) gathered "facts" about Winters' treatment and whether doctors generally consider fertility treatments to mean IVF. The Administrator reviewed three articles in popular periodicals like Time Magazine; a letter from a hired consultant who did not specialize in reproductive technology and who could not be located for trial; and an "IVF" notation

in Winters' medical records (although the Administrator did not speak to Winters' physician and these records were not part of the appellate record). *Cf.* Respondents' brief at 9-10. There is no evidence the Administrator even knew what GIFT was.

These "facts" allegedly were relevant to whether GIFT actually constitutes IVF, *see Kunin v. Benefit Trust Life Ins. Co., supra,* 910 F.2d 534, 538 (9th Cir. 1990) (finding a more comprehensive investigation unreasonable); they are not even arguably relevant to an interpretation of the policy term "IVF." In contrast, contra proferentem *is* relevant to an interpretation of "IVF," because it aims to interpret the

policy *itself*, the drafter's deemed intent, as opposed to the facts.

In this Petition, the issue is the meaning of the ambiguous IVF exclusion – whether it covers GIFT procedures – *not* whether Winters' procedure in fact constituted IVF. Therefore, whether the Costco's administrator abused his discretion in conducting his investigation is irrelevant, because it has no bearing on the scope of Costco's IVF exclusion.

In contrast, the applicability of contra proferentem *is* relevant to the scope of Costco's IVF exclusion. If this Court does not apply contra proferentem, Costco's expansive interpretation of "IVF" will stand, even though Costco's conflict of interest may have influenced its interpretation, and Winters will not receive the health bene-

fits she seeks. If this Court applies contra proferentem, however, the IVF exclusion will be interpreted in Winters' favor, and Winters will recover health benefits.

C. The "Covered Charge" Provision is not Properly Before this Court Because it was not Considered Below; Moreover, it does not Preclude Coverage for GIFT.

The "Covered Charge" provision is not properly before this Court because none of the three forums below (the Administrator, the district court, or the court of appeals) considered it. *See Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 552, 554 (9th Cir. 1995), App. A at 2505, 2522; *Winters v. Costco Wholesale Group Benefits Program and Concept Administrators, Inc.*, No. C92-

581WD (W.D. Wash. July 26, 1993), App. B at 10-11.

Even if this Court were to address this new argument, it would not avail Respondents because the "Covered Charge" section does not preclude coverage for GIFT.

The "Covered Charge" section is not, as Respondents suggest, a list of covered, "medically necessary" operations or procedures. Rather, it is a list of general medical expenses that are covered if incurred for any specific operation or procedure covered elsewhere in the Plan. Therefore, Respondents' assertion that the "Covered Charge" list does not specifically mention GIFT is inapposite.

For example, "Covered Charges" include the "semiprivate [hospital] room

rate . . . reasonably necessary services and supplies provided by the hospital . . . the performance of the surgical procedure . . . the administration of anesthesia for the surgical procedure . . . [and] the postoperative care for the surgical procedure." *See* Costco Plan, Article V §§ 5.1, 5.2, 5.3, reprinted in the Appendix to this brief.

Winters' GIFT expenses consisted of such things as prescription drugs, doctors' fees, operating room fees and hospital fees. Since all these items appear under Costco's "Covered Charge" provision, Winters' GIFT expenses are "Covered Charges" for which she is entitled to reimbursement.

D. The Petition Accurately Describes the Circuits' Diverging Contra Proferentem Holdings.

As evidence of the circuit split, Petitioner respectfully refers the Court to the Petition.

Petitioner emphasizes that no circuit, with the sole exception of the Ninth Circuit in the instant case, applies contra proferentem to third-party plans but not to self-insured plans. The *Winters* panel did not explain why it made this distinction; nor did Respondents offer a reason for the distinction in their brief.

III. CONCLUSION

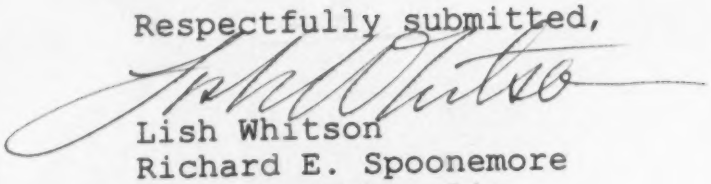
The Ninth Circuit's *Winters* decision creates a paradox by removing the protection of contra proferentem where insureds need it most: where the em-

ployer is both insurer and claims administrator. Such an employer has a fiduciary duty to its employee/insured, and faces a conflict of interest that may taint its claims denials under ambiguous terms. By holding the employer responsible for ambiguous drafting, contra proferentem provides the sole check against this conflict of interest and at the same time encourages unambiguous drafting.

By granting certiorari and ruling for Winters, this Court will end the Ninth Circuit's paradox. In so doing, this Court will also resolve the circuit split regarding the applicability of contra proferentem under ERISA. Both resolutions will further ERISA's purposes of employee protection, clarity of

coverage, and uniformity of insurance regulation.

Respectfully submitted,



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APPENDIX

ARTICLE V

Covered Medical Charges

5.1 General. This Article defines Medical Expenses which are considered Covered Charges by the Plan. Charges other than Covered Charges are not considered for Benefit payment by the Plan.

5.2 Inpatient Hospital Expense. Covered Charges include the Medical Expenses incurred for Inpatient Hospital Confinement including the cost of:

(a) Semiprivate Room Rate, Intensive Care Unit, and/or the Coronary Care Unit; and

(b) Reasonably Necessary services and supplies provided by the Hospital.

5.3 Surgical Fees and Administration of Anesthesia Expense. Covered Charges include Medical Expenses incurred for a Surgical Procedure including:

(a) the performance of the Surgical Procedure by the Physician(s) and his assistant;

(b) the administration of anesthesia for the Surgical Procedure by an anesthesiologist or a registered nurse anesthetist (R.N.A.); and

(c) the postoperative care for the Surgical Procedure rendered by the Physician(s) who performed the procedure, including periodic follow-up visits.